Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ye ar **Physician** July 12 2008 11:30 A Gloria Isabel Gilbert /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner Howard Brighton Gardens Columbia If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 1 □ M 2 🕏 F Director 87 15, 1920 Maryland <u>218-18-0470</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 12821 Flack Street 20906 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 XNo Maryland 21215-0036 White 1 ☐Yes 2 No Specify: Specify: à 3 → Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administration Claims Researcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rufus Bozman ည Lillian Bullen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Granddaughter 561 Jamestown Court; Edgewood, MD 21040 Christine Grant Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA Cem 7/21/2008 Owings Mills, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses 23a, Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alzheimer's Dementia years disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Po in the past 12 months? Month Year Day 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate I 2 🗆 No 1 □Yes 2 🖾 No 1 TYes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu M 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.D. July 14, 2008 D56531

Registrar
DHMH 17 Rev 1/200

State

Dr. Harry Li

31. Date filed (Month, Day, Year)

8600 Snowden River Pkwy, #301; Columbia, MD 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Registrar's Signature

08-05335 Paul Gerard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

aui Gerard		State of Maryland / Department of Health and Mental Hy 1-For State Certificate of Death		2 U U	8 2300
Physicia	n/	Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Deat	n I	3. Time of Death
/ledical Examin		PAUL (NMN) GERARD 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month July 11, 20	008 4c. County of Death	2340 hrs
· **		Greater Baltimore Medical Center Towson		Baltimore Cou	nty
Funeral	ı	Months Days Hours Min	7	Cou	hplace (State or Foreign I untry)
Director	L	155-28-4296 1KM 2 F 99 Yrs.	Apr. 1	9, 1909 Nev	/ Jersey
any.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show d at once.	5	Maryland Baltimore Parkville			1 Yes 2 X No
Maryl rr 28a-	Director	10e. Street and Number 10f. Zip Code 21234		ng. Citizen of What Cour	itry?
		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-		can Indian, Black,
death or item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
rs after ural",	۾	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 K No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w	ork done	Specify: WI	nite
72 hour	흥	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired to the control of the control		- 1	
5036 within 7, iene.	ompleted	11 Lt. Colonel	(Cinch Adiaballa A	U.S. Gover	nment
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; injury or other traumatic eyeut, the Medical Examiner.	ပ္ကို	17. Father's Name (First, Middle, Last) Paul Louis Gerard 18. Mother's Name Celina		Gaubert	
213 nould b d Men is marl	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			, Zip Code)
MD and 2 sho salth and 2 sho cm 27 is raumati		Patricia Gerard / Daughter in Law 1012 Sanderling Circ	le, Aud	ubon, PA 19	1403 Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	7 00	D. 11 days	
altin mit. Pe partmer portan	-	4 Donation 5 Other Specify: Holy Rosary Cemetery 7-1 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Ho	7-08	Baltimore,	Maryland
Per Per III		1317 Cokesbury Roa	d. Abin	adon, Marvl	and 21009
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arr	est, snock, or neart	Approximate Interval Between Onset and Death
xaminer	-	Immediate Cause (Final disease or condition resulting in death) A Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	-		
	_	Sequentially list conditions, b			
Ţ.		cause. Enter Underlying Cause			_
executed an and all - transit	Ě	events resulting in death) Last Due to (or as a consequence of): d.	_		
an a	Medical	UNPENDED AMENDED			
876C ifficate og phys	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of deliver Month	y Day Year
Box 687 Le death certificathe attending pred for use as the	Physician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
D. B. tribe de by the ached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
rds, P.O. requires that the been signed by hould be detach	d b		1 Ye:		
cords law requestable has been 2 should	Completed		24a. Was autor	1	utopsy findings available completion of cause of
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/ital	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 26. Place of Death (Check Pl	ng Home 5	Residence 6 Othe	r:
ion of Vital Records, tending Physician: The law requirent or: After this certificate has been the funeral director, page 2 should	۲	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred	
ivision or Attendi after death. Director: I in by the f	gtio	1 V Natural 5 Pending Investigation 2 Accident 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc.	20f Leastine /	Street and Number or Ri	ral Pouto Number City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, \$		aran reductive medicing only
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burin		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cau	se(s) and manner as sta	ed.
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier (29c. License number)	at the time, date	and place, and due to the 29d. Date signed (Mo	
		ard Hallan O.C.M.E.		July 12, 2008	-,,,,,,
12x1	}	30. Name and address of person who completed cause of death (Item 23a)			<u>.</u>
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120)1		
Sta Regist	ate rar	11 21 1 7 17 11 10 1 20 20 21 21 2 2 2 2 2 2 2 2 2 2			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O.S **Physician** 4:20 a. M 0 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign
Country) **Funeral** Director of Decedent death with the Maryland 10a. State 10b. County 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examiner must be notified at by Funeral Director 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, **II** 18. Mother's Name (First, Middle, Maiden Surname) Maryland Father's Name (First, Middle, Last) Be Informant's Name/Relationship (Type. Prht) cugiter 19b. Mailing Address (Street and Numb or Rural <u>Ro</u>ute Number, Baltimore, 20b. Place of Disposition Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of a shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSis **Physician** /Medical Due to (or as a consequence of): Examiner NELIMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ESRO The law requires that the death certificate be executed On and Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 3 Probably 4 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000

State Registrar SABAEVA

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD, BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#32. Registrar's Signature

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2008

			1 - State of N	Maryland / Dep <i>Ce</i>	partment of F e <i>rtificate of I</i>			giene Reg. No.2 0 0	8	23004
			negistrar 1. Decedent's Name (First, Middle, Last)		or imodio or i		2. Date of De	ath		3. Time of Death
	Physici /Medic		Charles Dannell Hicks Sr.				July 1		Year 08	4:10 pm
	Examin	er	4a. Facility Name (If not institution, give street and number	>r)		r Location of Death		4c. County o		
	Funeval		Seasons Hospice 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday	Randalls If Under 1 Year		8. Date of Bir	Balt Balt	inore 9. Birthpla	ce (State or Foreign
	Funeral Director		218 - 58-5500 X□ M 2□ F	55 Yrs.	Months Days	Hours Min.	8. Date of Bir	952 ^{ar)}	Country	MD MD
	pug 🔥		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				100	d. Inside City Limits
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	r 28a-	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of WI	nat Country	y?
	th with		3611 Hilmar Road		21244			USA		
	r deal	Funeral	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S. 13	B. Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No Rican, etc.)	- 14. Race Black	- Americar	3.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Extra	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date	No	1 □Yes 2√∑No	Specify:		Specify	rican-	Americ <i>a</i> n
Baltimore, Maryland 21215-0036	2 hour	ted	15. Decedent's Education	16a. Dec	cedent's Usual Occup	ation		16b. Kind of Bus	iness/Indu	stry
215	thin 7 ne. ian "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c	life	re kind of work done of . DO NOT use retired	during most of workir d)	g	D 1	0.1	
2	led wi Hygier her th nt, Ih		12th	1	Maintence T	18. Mother's Name	/Eirot Middle	Baltimore		·
and	should be filed within and Mental Hygiene. is marked other than is umatic event, the Mannatic event ev	9 Be	17. Father's Name (First, Middle, Last) James Hicks			Frances Bi		, ivialuen Surname	,	
ar Z	should be f and Mental s marked o umatic eve	ြ	19a. Informant's Name/Relationship (Type. Print)	19b. Mai	iling Address (Street			er, City or Town, S	tate, Zip C	Code)
Ž	1 and 2 Health a em 27 is other tra		Frances Hicks/Mother	3611	1 Hilmar Roa	d, Windsor M	ill, MD	21244		
ore	ges 1 at of He If item		20a. Method of Disposition 11☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	20b. Place of Disp cemetery, cri	position (Name of ematory or other plac	ce)	ate	20c. Location - C	ity or Tow	n, State
Ē	tt. Pag rtmen rtant; njury		4 Donation 5 ☐ Other (Specify)	King Memor	rial Park	7-16-		Woodlaw	n, MD	
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Soprifure of Funeral Service Licensee	Miller 6	22. Name and Addre 200 Libertyl	^{ss of Facility} Wyli Road Randal	e Funera 1stown	l Hame P.A MD 21133	of B	alto. Co.
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not e					, A	Approximate nterval Between
4	Physician		Immediate Cause (Final disease or condition		NAL DI	SEASE			C	nterval Between Onset and Death
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68760,	ifficate be executed g physician and as the burial-transit	edical	d							
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Ö.	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Live bird. 1 ☐ Yes 2 ☐ No 4 ☐ Pregnan	t at time of death 5	B ☐ Ectopic pregnanc □ Other (<i>sp</i> ec <i>ify</i>) _	у		Mon	th D	yay Year
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ds,	w requires that the de s been signed by the should be detached	by	Part II. Other significant conditions contributing to death	-	underlying cause give	en in Part i.	1 🗆 1		Bulle to the	~
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		Be C	25. Was case referred to medical examiner?			26. Place of Death	1 ☐ Yes (Check only o		□Yes 2	
	Physician: this certific ral director, I	ဂ္	1 ☐ Yes 2 No Hospital: 1 ☐ Inpa	atient 2 ER/Outpati		4 U Nursing Hon		dence 6 🗖 Othe		HOSPICE
00	ding Ph h. After th funeral	tion:	T La Tatula	njury 28b. Time <i>Day, Year)</i> Injury	Worl	yat ⟨? Yes 2 □No	8d. Describe	how injury occurre	d	
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ā	ital or is afte al Dir led in	Certification:	4 Hornicide building,	etc. (Specify)			City or To	wn, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director. A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the besicned and manner on the basic and manner	s of examination and/or	ath occurred at the tir investigation, in my o	me, date and place, a ppinion, death occurre	and due to the ed at the time,	cause(s) and mar date and place, a	nner as sta nd due to t	ited. he cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. Licens	e nu m ber		29d. Date signed	(Month, Da	ay, Year)
			I while there Do		11459	73/		JUN 151	4 200	8
	3		30. Name and address of person who completed cause of Deborah PIErro	of death (Item 23a) (Type Q.5 M.A.(N.S.T) strar's Signature	Print) NET RE	ISTERSTON				
	Sta Registr		31. Date filed (Month, Day, Year) 2008	strar's Signature	Sili!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 23005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day KENNETH DALE HOILAND JULY 14 2008 12:55 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Min. 1 X M 2 □ F Hours 502-60-2657 Feb. 3, 1953 North Dakota Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TX No Maryland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2506 Butternut Court 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lab Tech U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy (unk) Hoiland Mabel (unk) Amerine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dixie L. Hoiland / Wife 2506 Butternut Ct., Edgewood, Maryland 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-19-08 Hilltop Service Corp. Towson, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. usa Approximate Interval Between Onset and Death 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonia days Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/N No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

physician

the

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certificate has page 2

funeral

filled in by

within 24 hours a

To the Funeral I

completely filled

I or Attending Physician: after death.

Director: After this certifications

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Completed

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Certification: To

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The law requires that the

Holland, Kenneth, Dal Division of Vital Records.

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau once.

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner is use the multiple all

5.1 and 2 should be filed will f Health and Mental Hygier tem 27 is marked other th

death with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE:

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

and manner stated.

autopsy perform 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

26. Place of Death (Check only one,

D	Hos	pital: 1 Inpatient	2 🗆	ER/Outpatient	3 🔲	DOA	Other:	4 Nursing F	lome	5 Residence	6 ☐ Other	(Specify)
5 Pending investigation	1	28a. Date of Injury (Month, Day, Ye		28b. Time of Injury	M		Injury at Work?	2□No		. Describe how inju		
6 ☐ Could not be	9	One Disease of Injury At home form street forty office								Location (OL		

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Milchi klun	l

determined

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kharalam. D. 500 lupser 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10e, 19b per th 9881 7-17-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** Ann Ε. Hagan July 13, 10:40 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice Of Chesapeake Linthicum Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 02/17/1944 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 M 200 Days Hours Min. 033-32-6479 64 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other treumetic event, the Modical Eventses on 28a-f show once. 10a, State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits VA Alexandria Alexandria City Director 1 XYes 2 No 10e. Street and Number Oakcrest
1722 Oak Crest Drive 10f. Zip Code 10g. Citizen of What Country? 22303 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No Specify: Completed by 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney LAw 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William M. Hagan Arline McCarthy ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Orage Floor and Number or Rural Route Number, City or Town, State, Zip Code)
1722 Oak Crest Drive, Alexandria, VA 22303 Allen Durling / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State St. Mary Cemetery 07/19/2008 4 ☐ Donation 5 ☐ Other (Specify) Needham, MA 21. Signature of Euneral Service Licensee Dorota Marshall 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Avenue, Baltimore, MD 21230 : Marchall Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. nset and Death Immediate Cause (Final **Physician** ACHTE MYELCID LEUKEMIA disease or condition resulting in death) 8 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the deeth certificate be executed attending physician and for use as the burlal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☒No Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t lirector, page 2 s 24a. Was an autopsy performed' 1 □Yes 1 ☐ Yes 2 🗆 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) HOSPICE 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funerel Director: 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057805 July 14, 2008

Registrar
DHMH 17 Rev 1/2001

State

Baltimore Maryland 21287

30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)

2008

Room 290

32 egistrar's Signature

orleans Street

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 9:00 Hurt **Physician** AMES 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist OWSON tospice 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 68 218-40-8076 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Exacting out to indiffed at 1 Yes 2 □ No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: <u>چ</u> 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION LABOTER 9HK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Olivet Centery July 18 2008 Frederick Maryhans permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee Ku complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of shock, or heart failure. Li CANCER Immediate Cause (Final Co Con menths **Physician** etastat.c resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 🗆 No 1 Yes 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 € No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certified

State Registrar Day, Year) 33 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32 Registra

legistrar's Signature

N. Charles St. Balts and 21204

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month GINA HAMRLIK 1321PM 2008 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LNIVERSITY OF MARYLAND MED CENTER BALTIMORE 8. Date of Birth (Month, Day, Year) Oct 29,1944 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 K F Days Hours Min. 218-42-2604 63 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits show 28a-f sh notified 1 ☐ Yes 2X No Directo MD Anne Arundel Pasedena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? if item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be in 1923 North Avenue 21122 USA death Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite ☐ Yes 2 🔀 No FYes, Give 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A House Cleaner Home Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Lehner Regina Stuprich ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1923 North Avenue Pasedena, MD 21122 Leonard A. Hamrlik - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of Himportant: If ite any Injury or of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Mary 7-18-08 Dundalk, MD 21. Signature of Funeral Service Lieensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician MESENTERIC ISCHEMIA /Medical resulting in death) Due to (or as a consequence of) Examiner RESPURATORY FAILUREequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical use as the 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month 4□Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient Pospital or Attending Post Hours after death.
Funeral Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifies 1 X ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner started. (Check only 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) 79532 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W 22. S. GREENE ST Slavih BALTIMORE MD 21201 JUSTIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Amend 19a, perFH, G881 7/25/08 TT State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** 8:00pM Clara Ruth Hurley /Medical 28. 2008 June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Genesis Heritage Nursing Center Dunda1k Baltimore | If Under 24 Hrs. | 8. Date of Birth Hours | Min. | April 18, 1926 | Maryland 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 Ū F 215-24-5057 82 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Wedical Exacting and the molified at Director MD 1 ☐ Yes 2 ☐ No Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7232 German Hill Road 21222 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates: <u>≽</u> 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Vogel Catherine Heath ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trau once. Barbara Semitt-Daughter 620 Woodsmans Way Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 17/2/2008 Baltimore, Maryland 22. Name and Address of Facility Charles S. Zeiler & Son 21. Signature of Funcial Service Licensee 6224 Eastern Avenue Baltimore, MD 21224 23a. Par 1. Enter the disease, shock, or heart failure. checomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially llst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit and to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending asn IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the 9 Unknown ģ signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy perform certificate 1 □Yes 2 1 No 2 No 1 ☐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 1 🔲 Yes 2 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 5 ☐ Pending investigation Natural within 24 hours after death. To the Funeral Director: A 2 Accident 1 ☐ Yes 2 No filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 29b. Signature and title of certifier State 7 2008 Registrar

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Physiciar Medical Examin	n/ er	1. Decedent's Nam James Jones	3								2. Date of Do Month July 12,	2008	y Year		3. Time of Death 2345 hrs
	1	4a. Facility Name (i North West		n, give str e et	and nun	nber)			Town, or I	Location of Dea n	ith	4c. County of Death Baltimore County			nty
Funeral		5. Social Security N		6. Sex	1	7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.						Birth(M	IM/DD/YYYY)		nplace (State or Foreign
Director		077-50-6888	3 .	1 XM 2	F		50	rs. Mon	ths Days	Hours M	^{in.} 4–21 – 1	.958		Cou	NY
ny	-	Usual Residence o 10a. State	f Decedent 10b. County			10c. City	, Town or Lo	ation							10d. Inside City Limits
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Marylar 28a-f s	Funeral Director	10e. Street and Nu	mber					10f. Z	ip Code			10g. Citizen of What Countr			try?
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)36 thin 72 re. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Food Processor						or		N	Northwest Hospital		pital		
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2121 Ild be f Vental marked event,	Philip Jones Catherine Morse 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow									. City or Tow	a. State.	Zip Code)			
AD 2 2 shou h and h 27 is r	_	LaShae Green/ Daughter 1330 Vida Drive, Gwnn Oak, MD 21207							,, 01010,	т. — р сосс,					
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumain	1	20a. Method of Dis	position V Cremation	n 3 Rei	noval fro		Place of Dis			· 1	Date		Oc. Location -	•	
imo Page ment o tant: or oth		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Depend on 5 Other Specify: 21. Strature of Funeral, Service Licensee 22. Name and Address of Facility Wile Funeral							_	Baltimon	,				
Ball permit Depart Impor injury		21. Synature of Fu	uneral Service	Licensee	1110	de					lie Funer ndallstow			of	Balto. Co.
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/Medical Examiner	1	Immediate Cause	(Final disease	a. Acute	Coro	nary Artery		sis							Death
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68760, certificate be nding physicise as the buri	/Mec	IF FEMALE: 23b. Was decedent	t pregnant in t			outcome of pre			0				23d. Date of		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medic	Part II. Other sign		9	Unkno	own death but not	roculting in t	. undoriv	ina cause i	riven in Part I	23e D	id tobar	cco use contr	hute to	the cause of death?
P.O es that i	≥	Tart II. Other sign	inicani condi	tions contin	buting to	death but not	resulting in t	ie dilucity	ing cause (giveir iir i aic i	1				pably 4 🗸 Unknown
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ivisior I or Attend after death Director:	Certification:	2 Accident 3 Suicide		estigation 2	8e. Plac	e of Injury - At	home, farm,	street, fact	ory, office I	ouilding, etc.		on (Stre		er or Ru	ıral Route Number, City
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Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical	(Check only one) 2	1/1	aminer:On th	e basis	of examination					and due to the d ed at the time, d				
To COT	ğ	29b. Signature and	d title of certif		nanner s	tated.	_		29c. Licens	se number		2	9d. Date sign	ed (Mo	nth, Day, Year)
		Care	al	46	le	lai	~		O.C.	M.E.			July 13, 20	800	
\	Ì	30. Name and add		n who comple ssistant M				n Stree	et, Baltim	ore, MD 21	201				
	ate	31. Date filed (Mor			32 Re	egistrar's Sign		and the same							
Regist	rar	JL	15 7 1	F000	1	Marien Sec									

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 2301 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year ohnston richard 2008 06:26 101 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death The Johns Hopkins Hospital **Baltimore City** N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) XM 2□ F 578-48-6369 77 APR 14 1931 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Humacao Punta Santiago 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Calle 2, A31, Villa Pal Mira 00741 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No If Yes. Give — 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: **Korea** 1 ☐ Yes 2 XNo 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Engraver Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Johnston** John **Florence** Kennedy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy I. Johnston - wife Calle 2, A31, Villa Pal Mira, Punta Santiago, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Metro Crematory, Inc. 7/17/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Steven H. 22. Name and Address of Facility Cremation Society of Maryland, Inc. Williams 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21228 Approximate Interval Between Onset and Death Immediate Cause (Final failure disease or condition resulting in death) renal Due to (or as a consequence of): failure Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last liver Due to for as a consequence of infection nepaths Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 5 Residence

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

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Director

Funeral

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Completed

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Funeral

Director

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Items 23a

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death v

within 72 hours after

2 should be finance and Mental H

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any Injury or other traumatic ew It item 27 is marked

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified

burial-transit and attending physician Box 68760. the as asn The law requires that the death for of Vital Records, P.O. the ģ been signed page 2 should Physician:

Division

or Attending

Hospital

Examine Physician/Medical 2 Completed certificate has Be P this Certification:

Director: After death. the filled in by after hours 24 hours

To the within 2 10

Babak UI ...
31. Date filed (Month, Day, Year) State Registrar

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orandi, MD 32. Resistrar's Signature

5 Pending investigation

6 Could not be determined

28a. Date of Injury

and manner stated

REUSI

(Month, Day Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) Kes-000 2008

28d. Describe how injury occurred

28c. Injury at Work?

1 ☐ Yes

2 No

600 North Wolfe St, Baltimore, MD, 21287

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

Physician	1. Decedent's Name (First, Middle, Last) Boy Jenkins	2. Date of Death Month Dey	Year 0710					
/Medical Examiner	4a Fecility Neme (If not institution, give street and number) VNIVERSITY OF MARYLAND BALTIN	cation of Deeth 4c. County						
uneral irector	74 TIS. 01 01 .	8. Date of Birth (Month, Day, Year) June 20, 2008	Birthplace (State or Fore Country) Maryland					
ž.,	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Lim					
r 28a-f show inotified at irector	MD Baltimore		11√∑Yes 2□					
or 28a a nort	10e. Street end Number 10f. Zip Code	10g. Citizen of V	What Country?					
23a c	10 N. Bruce Street 21223	US	SA					
al', or items 23s or 28s-f's Examiner must be notified by Funeral Director	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 12. Wes Decedent Ever in U,S. Armed Forces? 1		e - American Indian, ck, White, etc.					
ygiene. Te than "natura It, the Medical E Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of B	usiness/Industry					
d out		infant (First, Middle, Maiden Suman Jenkins	ne)					
and Mental is merked of aumatic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura.		State Zin Code)					
	University of Maryland Med Ctr 22 S. Green Street Ba		21201					
5 = 9	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☑ Other (Specify) in State		City or Town, State					
Departmer Important: any Injury phce.	21. Signature of Emeral Service Licensage Ronald S. Wade, Director State Anatomy Board Baltimore, MD 21201		ore Street					
ysician	23a. Pert1. arter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, wheart failure. List only one cause on each line.	r respiratory arrest,	Approximate Interval Between Onset end Death					
Medical caminer	Immediate Cause (Final disease or condition resulting in deeth) e. EXTREME PREMATURITY Due to (or as a consequence of):	1	1					
physician end is the bural-transit edical Examiner	Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Cause (Disease or injury)							
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been signed by the attand should be datached for us ieted by Physiclan/	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	- V-	ntribute to the cause of dea					
ned be date		1 ☐ Yes 2 No	3 Probably 4 Unkn					
% C □		24a. Was an autopsy performed?	24b. Were autopsy finding available prior to completion of cause of death?					
Page Corr		1 Yes 2 No	1 ☐ Yes 2 ☐ No					
certificata has t lirector, paga 2 s o Be Compi	25. Was case referred to medical examiner? 26. Place of Death	(Check only one)						
it is	The state of the s	ne 5 Residence 6 Oth						
within 24 hours after death. To the Funeral Director: After this certificata his completaly filled in by the funeral director, paga Medical Certification: To Be Com	1 DNatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be	8d. Describe how injury occur						
erst Directified in b	4 ☐ Homicide building, etc. (Specify)	City or Town, State)						
in 24 hound the Funer pletaly fill edical	29a. Certifier (Check only onle) (Check only onle)	nd due to the cause(s) and ma d at the time, date and place,	and due to the cause(s)					
To the comple	29b. Signature and title of centifier 29c. License number	1	d (Month, Day, Year)					
·tt.	AU4176435 RI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. GREENE ST. BALTIMORE, MD 212	OI SARA	K RANKON					
State Registrar	31. Date filed (Month, Day, Year) 32. Registrer's Signeture							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July T₄ **Physician** 2008 5:30 P M THERESA S. JONES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GILCHRIST HOSPICE TOWSON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth Month, Day, Year, OCT 16,1928 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🙀 F 087-22-0954 79 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location r than "natural", or Items 23a or 28a-f show the Medical Exerciper must be notified at ty⊡Yes 2 No Director N/A BALTIMORE MT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 USA 5916 WALTHER BLVD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 If Yes, Give Year or Dates Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BANKING SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fillent of Health and Mental Hett If item 27 is marked othry or other traumatic even Be JAMES McCARTHY MARY KING ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21206 5916 WALTHER BLVD G. VIVIAN NAPERT-NIECE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State permit. Pages Department o Important: If i any Injury or 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 7/17/08 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 6415 BELAIR RD BALTIMORE, MD 21206 Part 1. Enter the disease, o shock, or heart failure. Lis Approximate Interval Between Onset and Death pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest y one cause on each line. Immediate Cause (Final **Physician** Wells disease or condition resulting in death) N9 /Medical Due to (or as a c / sequence of): Examiner Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Directs for as a consequence off-Examiner Physician: The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Year 5 Other (specify) detached for 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performe 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dether (Specify) NOSPI Q 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at Work? 27. Manner of Death 28c. 28d. Describe how injury occurred Hospital or Attending 1 Matural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 24 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALVES Charles 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 1 7 2008 Confession . Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kremer J: 450 15 Louise 20008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Charlestown Care Center Catonsville 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 96 1912 Maryland Director <u> 218-36-8681</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show direct Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Marvland | Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 709 Maiden Choice Lane 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【X Xo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 🗓 No White Specify: ģ XX Widowed 4 □ Divorced er than "nature the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the M Supervisor Employment Counseling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar E Phillips Marv Horseman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Allegheny Avenue Towson, Maryland 21204 Beth Ann Kremer Lamb Step-Dtr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Moreland Memorial Park July 19,2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Strvice Lice see 22. Name and Address of Facil Mitchell - Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurer. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) multisys & m Physician organ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any Lacing I, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has b irector, page 2 sl 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 90 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maiden Chrice Lane, Cuton sville Bullin 31. Date filed (Month, Day, Year) 82. Registrar's Signature 1 7 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

11cm 23a per doc 881 7-17-08 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 0 8 For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** 11:35 AM 9, 2008 July Katherine Janet Lamb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Days Hours Months 1 ☐ M 2 🔂 F Yrs. Feb. 16, 1938 Virginia Director 70 225-48-5876 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a State r 28a-f show 1 ☐ Yes 2 X No Director Harford Darlington Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code other than "natural", or itema 23a or vent, the Medical Examiner must be: 4401 Conowingo Road 21034 USA Funeral 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Š 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Clerical Power Plant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic avent ORE: Be Winnie Catherine King William Gordon McDaniel 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 385, Darlington, Maryland 21034 John T. Lamb Jr. / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Buria / 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Otyle (Specify) Darlington Cemetery 7-21-08 Darlington, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral 50 W. Broadway, Bel Air, Maryland 21014 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Severe Pneumonia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence or): Exami ettending physicien and for use es the burial-tra that initiated events Box 68760. resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy The law requires that the death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ate has been signed by the e pege 2 should be detached t Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Chronic renal failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? WIHERING 1 Yes 2 No After this certificate funeral director, peg 2 No 1 ☐ Yes Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 [Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 1 Yes 2 No death. investigation nerei Diractor: A filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire ŏ 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of sprtifier 1 63420 9,2008 Sar Khara July 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 S. Union Ave, Havre de Grace 21078 501 Kharal Lubair 32. registrar's Signature 31. Date filed (Month, Pay, Year) State 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 17 20a per fb 881 7-17-08 vt. State of Maryland Poepartment of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day X/AYNE KUTR /Medical JULY 9:53 2008 12 4a. Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/21/1933 367–32–7771 **Funeral** Birthplace (State or Foreign Country) 1 XM 2 □ F Director MT Usual Residence of Decedent 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ID Bonneville Idaho Falls 1X Yes 2 □ No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2011 Virginia Avenue Funeral 83404 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 BYes 2 No
If Yes, Give Korean War 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 \$ 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 No White "natural", Specify Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) marked other than Hygiene. College (1-4 or 5+) Nuclear Engineer Nuclear alth and Mental Hvo 17. Father's Name (First, Middle, Last)
Waino Arthur Letho 18. Mother's Name (First, Middle, Maiden Surname) Sigrid Sofia Kutramo Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked c any injury or other traumatic eventoe. Lehto 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lehto / Wife Mae 2011 Virginia Avenue, Idaho Falls, ID 83404 Baltimore, 20a. Method of Disposition

2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Eagle Rock Crematory 07/21/2008 4 ☐ Donation 5 ☐ Other (Specify) Idaho Falls, ID 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 Fast Fort Avenue, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** SOPHAGEH Onset and Death disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events MUMONARY FIBROSI Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): DISEASE attending physician and resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery be detached for ☐ Live birth 2 ☐ Fetal death in the past 12 months? 3 - Ectopic pregnancy Pregnant at time of death Yes 2 🗆 No 5 Other (specify) Month Day Year been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 23e. Did tobacco use contribute to the cause of death? APTH RITIC director, page 2 should Completed 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 2 No 2 No 1 TYPS or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 Yes 2 No 1 Xinpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient this 3 DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1.XNatural 5 Pending investigation Injury death. 2 Accident after death 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospitai 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 7 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) RES-000 07/12/2008 VO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIR

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Pay,

NEYCHEL

2008

ogistrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 19 42 PM Elizabeth Little 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗸 F Months Days Hours Min. 56 Director Dec 11, 1951 Maryland 214-58-6911 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Its Modical Examination and the number of 1 ☐ Yes 2 No Director MD Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number USA. 44 NAKOTA CT. 21220 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Department 12 Jerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Hermin မှ Thomas whimown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra 1 and 2 s Health ar Latany & M. B. Geniu NAKOTA ct, Middle River, mo 21220 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery Jul 18,2008 Dundalk, Mary kind remity 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Ficility
Runwed A. Chayson Funeral Service
270 Fred Hilton pass 13ala, md 21 21. Signature of Funeral Service Licensee Renald a Frager 13ala, ma 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hemorrhage **Physician** cerebral OF basal ganglia 32 415 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be execute burial-transi and Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ hypertension uncontrolled 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Completed cerebrovascular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 250000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD 21237 ssel mesc oclo 31. Date filed (Month fonth, Day, Year) State 2008 Registrar

DHMH 17 Rev 1/2001

			1 - State of Maryland / Departmen Certificate	t of Health and N e of Death		giene Reg. No.2008	23019
	Physici		1. Decedent's Name (First, Middle, Last) Mary Lipinski		2. Date of Dea Month July	Day Year	3. Time of Death 9:55p M
	/Medic			Town, or Location of Death	bury	4c. County of Deatl	
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	timore 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day 9 – 28 – 1	, Year) Co.	nplace (State or Foreign untry)
and	MC T		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location		_		10d. Inside City Limits
Maryl	a-f she	ioi	MD Baltimore				1√Yes 2□No
ith with the	23a or 28a unt be not	ral Director	10e. Street and Number 115 E. Melrose Avenue	21212	1	10g. Citizen of What Co	untry?
5-0036 72 hours after death with the Maryland	ital Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Exercicer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	lent of Hispanic Origin? (Sp olfy Cuban, Mexican, Puerto 2 X No <i>Specify:</i>	pecify Yes or No- Rican, etc.)		
15-C	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of we life DO NOT us	al Occupation k done during most of work e retired)	ing	16b. Kind of Business/I	ndustry
d Z1Z15 filed within 72	giene. er thar , tre	Somp	Elementary/Secondary (0-12) College (1-4or 5+) Home ma			in own	home
- m	and Mental Hy is marked oth aumatic event	To Be (17. Father's Name (First, Middle, Last) unk	18. Mother's Nam	e (First, Middle,	Maiden Surname) ur	nk
, Mar	salth and 127 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Attorney 19b. Mailing Address Shawn R. Harby 309 S. ((Street and Number or Rui			
Ilmore, Pages Lar	Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ★ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Nancemetery, crematory or of Holy Rosary	ne of ther place) 7-/2	1/08]	20c. Location - City or Baltimore	Town, State , MD
Dait.	Depar Impor any In once.		21. Signature of Funeral Service Licensee 22. Name an 263 S.	^{d Address of Facility} Jos . Conkling	seph N. St. Ba	Zannino ltimore, M	Jr. Fh ID 21224
	ysician Medical		23a. Part 1. [Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCIEROTIC Due to (or as a consequence of):			The second secon	Approximate Interval Between Onset and Death YEARS
	aminer	ier	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
), executed	attending physician and for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
oo/ou	g physicia ss the bur	edical	d				
DIVISION OF VITAL MECONDS, F.O. BOX 08/00, To the Hospital or Attending Physician: The law requires that the death certificate be executed	y the attending	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic principle 4 Pregnant at time of death 5 Other (spinor) 1 1 1 1 1 1 1 1 1			23d. Date of deli Month	very Day Year
law requires that	een signed b ould be deta	ĝ	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	iuse given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
VILAI NEC Iclan: The law r	n. After this certificate has been signed by the funeral director, page 2 should be detached	e Completed	25. Was case referred to medical			sy prior to death? 2 No 1 □Yes	topsy findings available completion of cause of
l VII	nis cert directo	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO	26. Place of Deat Other: 4 Nursing Ho		ne) ence 6 □Other (Spec	cify)
Attending Phy	or: After the funeral	ation: 1	1 Accident S ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation M	8c. Injury at Work? 1 □ Yes 2 □ No		ow injury occurred	
tal or Att	al Director: led in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office	28f. Location (S. City or Town	treet and Number or Ru n, State)	ral Route Number,
the Hospi	To the Funeral Dir	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred a common state of the basis of examination and/or investigation, and manner stated.	in my opinion, death occur	red at the time, o	date and place, and due	to the cause(s)
To	P CO	2	29b. Signature and title of certifier	D3((3G	2	29d. Date signed (Month	, Day, Year)
	5		29c. Signature and title of certifier 29c. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) JUL 1 7 2008 29c. 29c.	MEROSE	4V. B	ALTI MORE.	un 2/1/2
	Sta Registra	te ar	31. Date filed (Month, Day, Year) JUL 1 7 2008 Registrar's Signature		,		

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Funeral

Director

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ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at

Is marked other than

Health and Mental

Examiner the death certificate be executed physician and s the burial-trans attending p Ö ned by the detached signed by ۵. Division of Vital Records, page 2 Hospital or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 3. Time of Death Day 7:00AM Month **Physician** 200 Miriam 3014 Μ. Manrodt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUnder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) altmore 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Months 1 □ M 2 🖫 F 87 August 27,1920 Penn 203-10-4679 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6825 Campfield Road 11Q1 21207 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married If Yes, Give Year or Dates: 1 □Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 yr 's Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Miller Annie ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6825 Campfiled Road 11Q1 Rev. David H. Manrodt - Husband Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 7/19/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Maryland 21214 tan/Z Leonard J. Ruck, Inc. 5305 HArford Rd. Hauson 23a. Part 1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): day peror public Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examiner Duy to (or as aconsequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Ye ar Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No death? 1 ☐ Yes 2 MNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Man Wenth 068810 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4835 WEST BURSELL AVE HOFF BLALLE 46 BALTIMORE MD 21215 WEINTRAUB 31. Date filed (Month, Day, Year) 2. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.

Physician /Medical Examiner

Funeral Director

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

Completed by

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Certification:

Medical

show permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be redified at once.

Baltimore, Maryland 21215-0036 **Physician** /Medical

Examiner attending physician and for use as the burial-transit that the death certificate be executed ned by the a signed I

P.O. Records, Hospital or Attending Physician: The law requires ficate has been sign, page 2 should b Division of Vital this certific al director, After this funeral c n 24 hours after death.

Re Funeral Director: A pletely filled in by the fu death.

EVELYN NOWICKI

1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Jumm 16^{pay} 2008 Evelyn Marie Nowicki 8:15 A.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Social Security Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🔽 F 76 Months Days 220-68-0077 Aug21,1932 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Md. Baltimore City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6718 Danville Avenue 21222 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1
Yes 2
No 1 Never Married 2 Married 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) (unk) 17. Father's Name (First, Middle, Last) William Mayer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6718 Danville Avenue Baltimore, Md. Thomas F. Nowicki/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 7-21-2008 Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Kaczorowski Funeral Home, PA Tolar 1201 Dundalk Ave. Baltimore, Md.21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2X No 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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within 2

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD

17

31. Date filed (Month, Day, Year)

610X

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 23022

	1- For State Registrar Certificate	of Death	2000 2002 Reg. No.				
Physician/ cal Examine	Steven Matthew Pellerito	2. Date of I Month July 11	Death 3. Time of Death 2008 1637 hrs				
	Facility Name (if not institution, give street and number) 4903 Edge Moore Lane	4b. City, Town, or Location of Death Bethesda	4c. County of Death Montgomery				
Funeral Director			Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)				
ryland a-f show any. tt once.	Usual Residence of Decedent 10a. State 10b. County DC District Of Columbia 10c. City, Town or Lo Wash:	cation ngton 10f. Zip Code	10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country?				
th the Maryland 23a or 28a-f sh cotified at once I Director		20009	USA				
2 should be filed within 72 hours after death with the Maryland h and Mental Hygine Mental Hygine 77 is marked other than "natural", or items 23a or 28a-f she smatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No specify:	White, etc. White Specify:				
Agiene. other than "natu the Medical Exan Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 Of	dent's Usual Occupation (Give kind of work done g most of working life. DO NOT use retired) Ffice Manager	16b. Kind of Business/Industry Architecture				
should be filed v and Mental Hygi 7 is marked oth natic event, the TO Be CO	Paul Pellerito	18.Mother's Name (First, Midd Lucille	Cytacki				
d 2 should tth and Me n 27 is ma numatic er	Paul Pellerito / Father 257	iling Address (Street and Number or Rural Route 7 Stock Road, Metamora,	MI 48455				
permit, Pages I and 2 Department of Health Important: If item 2 injury or other traun	1 Burial 2 X Cremation 3 X Removal from State crematory of Perry Moun	position (Name of cemetery, or other place) t Park Cremetory 07/16/2	20c. Location - City or Town, State 003 Pontiac, MI				
2000	21. Signature of Funeral Service Licensee Dorota W. Marsh.	Charles L. Stevens 1501 East Fort Ave	Funeral Home Inc. nue, Baltimore, MD 2123				
ysician /ledical aminer	23a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Mixed drug intoxica Due to (or as a consequence of): Lamo	tion (Citalopram, Bupro	Between Onset and				
nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
and and	I d	f, perME,g881 7/24/08 T	T				
the attending physician ed for use as the burial hysician and for use as the burial hysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Contributing to death but not resulting in the underlying cause given in Part I. 23d. Date of delivery Month Contributing to death but not resulting in the underlying cause given in Part I. 23d. Date of delivery Month Capacity 9 Unknown 23d. Date of delivery 1 Live birth 9 Unknown 23d. Date of delivery 1 Capacity 9 Unknown 23d. Date of delivery						
signed by the lead of the detached			old tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown				
ficate has been significate has been significate has been significate has been significate has been significated because the suppose of the s		a	Vas an utopsy erformed? es 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No				
ysician: The his certificate director, page	25. Was case referred to medical examiner?	26.Place of Death (Check only one) ient 3 DOA Other Nursing Home 5	Residence 6 ✔ Other: Scene				
uspidan or Articiang Prystram: The law requires man the deam certificate by hours after death. Funeral Director: After this certificate has been signed by the attending lely filled in by the funeral director, page 2 should be detached for use as all Certification; To Be Completed by Physician	27. Manner of Death 1 Natural 2 Accident 1 Accident 2 Suicide 3 X Suicide 28a. Date of Injury (Month, Day, Year) Fnd 7/11/08 Fnd 4 28e. Place of Injury - At home, farm, s	*37 pm 1 Yes 2 X No presc street, factory, office building, etc. 28f. Locati	ibe how injury occurred Subject tionally overdosed on ription medication on (Street and Number or Rural Route Number, City				
		ccurred at the time, date and place, and due to the					
To the comple	Aflam Brasse (MD	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) July 12, 2008				
	· · · · · · · · · · · · · · · · · · ·	1 Penn Street, Baltimore, MD 21201					
State Registra		and a					
17 Rev 1/2001	January Sal Black	NAL					

	_	For State Registrar		laryland		artmen rtificati			and M	R	leg. No.	800	23023	}
Physicia /Medic		1. Decedent's Name (First, Middle	Last) EAVES							2. Date of Dea Month	Day	Year Zou y	3. Time of Death / 407 M	1
Examin	- 30	4a. Facility Name (If not institution, UNIVERS (TY OF	give street and number		- 4.1	4b. City,	Town, or I	Location o	of Death	2	4c. Co	unty of Death		
Funeral Director		5. Social Security Number 251-70-7327		ige (In yrs. la		If Under Months	1 Year Days	If Under Hours	, ,	8. Date of Birth (Month, Day 2–20–19	, Year)	9. Birth Cou	place (State or Foreign Intry)	n
aryland show dat	7	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore		, Town or Lo								10d. Inside City Limits	
r 28a-f	Funeral Director	10e. Street and Number		1 41.08		10f. Zip	Code				10g. Citizer	of What Cou		
ath with 23a ol ust be	ral D	36 Holamb Court				1	21220				U			
-UU36 hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	by Fune	11. Marital Status 1 □ Never Married 2X Marri 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces ed 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	? _ No		Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)		Race - Amer Black, White hecify: Afr		n
ING 21213-UU36 be filed within 72 hours after death with the Marylar Ital Hygiene. ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-4o	r 5+)	life. L	dent's Usua kind of wol DO NOT us Worker	rk done di	urina mos	st of workir	99		of Business/l $1 \# 16$	ndustry	
land 21 Id be filed w ental Hygie ked other ti c event, tb	To Be Col	10th 17. Father's Name (First, Middle, Inches Reaves	Last)		TEOU	worker		_	er's Name	(First, Middle,				
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic event	Η.	19a. Informant's Name/Relationsh Jacqueline Reaves/				-	•	nd Numb	er or Rura	Route Numbe		own, State, Z	ip Code)	
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)	3 ☐Removal from Stat	C	lace of Dispo emetery, crer	sition (Nan	ne of ther place	9)		ate		ion - City or 1	Fown, State	
Battir permit. P Departme Importan any injur		21. Signature of Funeral Service		16.2	22	2. Name an	d Addres	s of Facili	ty Wylio		. Hame	P.A. of	Balto. Co.	
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a 1010P	ed the death line. A THIC as a consequ	Do not ent			g, such as		r respiratory ar			Approximate Interval Between Onset and Death YEARS	
	ical Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consequ								11		
BOX 6 sath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal at time of de	Ideath 3□	⊒Ectopicpi ⊒ Other (sp					230	d. Date of deli Month	very Day Year	
COTGS, P.O. w requires that the debeen signed by the should be detached	þ	Part II. Other significant condition	ons contributing to death	but not resu	ulting in the u	nderlying c	ause give	en in Part l	1.			contribute to	the cause of death?	/n
	Completed									24a. Was autor perfo		24b. Were au prior to d death? 1 X Yes	topsy findings available completion of cause of 2 \sumbed No	le
r VITal ysician: is certifical director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 XInpa	ationt 2 🗆	ER/Outpatier	nt 3[]D0	Othe	or.		n <i>(Check only o</i> me 5 ☐ Resid		Other (Spe	oifu)	
ㅇ 호 눈률	\vdash	27. Manner of Death 1 Natural 2 Accident 5 Pendin investig	28a. Date of Ir (Month, I		28b. Time o Injury		28c. Injury Work			28d. Describe I				
DIVISION tal or Attending s after death. al Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	Zee. Place of	injury - At ho etc. (Specif	me, farm, str	reet, factor	y, office			28f. Location (3 City or Tox		Number or Ru	ıral Route Number,	
he Hospil n 24 hour he Funera pletely fillk	edical		g Physician: To the be Examiner: On the basis and manner	of examina										
To the within 2 To the complete	Σ	29b. Signature and title of certifie	2	7)		c. License						h, Day, Year)	
5		30. Name and address of person				Print)	1898				Ju	(y 14,9 1261	wy	
		SHIVEN PATE 31. Date filed (Month, Day, Year)	MD 22	Strar's Signal	CREEN	ES.	T	BALT	Mar	RE MÎ	2	1261		
Sta Registr	_	JUL 1 7 2	2003 State	strais Signa	Spa	es)								

08-05401 Judy Rambo Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

udy Rambo	State of Maryland 1- For State Registrar	Department of / Department of / d	Health and Mental H Death	ygiene _{Reg.}	No. 200	8 2302				
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)			Date of Death Month D	Day Year	3. Time of Death 0920 hrs				
ruta .	4a. Facility Name (if not institution, give street and number	er) 4	b. City, Town, or Location of Death	July 14, 200	4c. County of Death					
	4223 Berger Avenue		Baltimore		N/A					
Funeral Director	5. Social Security Number 6. Sex 7. A 213-44-5020 1 M 2 X F	Age (In yrs. last birthday)	Months Days Hours Min		(MM/DD/YYYY) 9. Birth Foreign Cour					
ny .	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Location	on			10d. Inside City Limits				
Maryland 28a-f show any 1 at once. ector	Maryland N/A		timore			1 X Yes 2 No				
the Maryland a or 28a-f sh lifted at once	10e. Street and Number		10f. Zip Code	10g.	. Citizen of What Count	iry?				
eath with the Maryland items 23a or 28a-f shoust be notified at once untrans Incertor Ineral Director	4223 Berger Avenue 11. Marital Status 12. Was Decede	ant Ever in II S 142 Wee	21206	naif. Van an Na	USA	an Indian Diad				
er death with o or items 23 c must be no	1 Never Married 2 Married Armed Force		s Decedent of Hispanic Origin? (S es, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,				
s after or miner m	3 Widowed 4 X Divorced If Yes, Give Year	1	Yes 2 No specify:	. <u>.</u>	Specify: Whi					
2 hours	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) College (1-4 of Elementary/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of voduring most of working life. DO NOT use retired to the control of th								
5-0036 Eled within 72 hour Hygiene. other than "natt the Medical Exact Completed	12	Cosmetic								
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To the Traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director			18.Mother's Name Net1	e (First, Middle, Mai	ilden Surname) INK •					
2121 hould be fil and Mental It is marked tite event,	19a. Informant's Name/Relationship (Type, Print)	Rural Route Numbe	er, City or Town, State,							
nore, MD 2 ages I and 2 shot nt of Health and 1 it: If iten 27 is r other traumante	Tamera O'Dell, Daughter		outh Main Street		1, NY 14042 20c. Location - City or 7					
10re ages 1 a nt of Hu t: If it	1 Burial 2 X Cremation 3 Removal from 5	State crematory or oth	ner place)		·					
Baltimore, MI pernit. Pages I and 2.8 Department of Health a Important: If item 27 injury or other traum.	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		matory Inc. 07/ acnabberuheral :		Baltimore,	Maryland				
	Thomas Gregor Jamas V	omas Gregor Jamas Kury 301 Frederick Ro								
Physician /Medical Systeminar 23a. Part I. Enter the disease, or complications that caused the disease, or complications that caused the disease. 23a. Part I. Enter the disease, or complications that caused the disease failure. List only one cause on each line. Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease										
₩ Examiner	Immediate Cause (Final disease or condition resulting in death) a. ATTICOSCICTOTION Due to (or as a core)		case			Death				
je	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cor	nsequence of):								
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a cor	nsequence of):								
and transit	d									
Box 68760, death certificate be executed the attending physician and of for use as the bunial - transit hysician/Medical Ex	UNPENDED AMENDED									
ox 6876 eath certificate attending phy for use as the I	23b. Was decedent pregnant in the past 12 months?	2	tal death 3 Ectopic pregn	ancy	23d. Date of delivery Month D	yay Year				
box 6876 the death certificate death certificate death certificate death of the attending phended for use as the Physician/IV	1 Yes 2 No 9 Unknown 9 Unknown		ner (Specify)							
~ # > # D		eath but not resulting in the u	nderlying cause given in Part I.		acco use contribute to t					
ords, P.C w requires that is been signed to should be deta				1 Yes	2 No 3 Prob	ably 4 Unknown topsy findings available				
of Vital Records, Ig Physician: The law requires the this certificate has been signeral director, page 2 should be 1. To Be Completed				autopsy perform	y prior to c	ompletion of cause of				
of Vital Recling Physician: The After this certificate finneral director, page 701: To Be Con	25. Was case referred to medical		26.Place of Death (Check	1 Yes 2	✓ No 1 Ye	s 2 No				
of Vital Big Physician: ther this certifineral director,	Tes 2 INC	atient 2 ER/Outpatient	- Ioines		esidence 6 🗸 Other	: Scene				
on of adding Pt. th. : After e funeral ion: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of It (Month, Day)	njury 28b. Time of Ir y,Year)	njury 28c. Injury at Work?	28d. Describe ho	ow injury occurred					
Division of tital or Attending us after death. ral Director: Aft liled in by the fume	2 Accident Investigation	Injury - At home, farm, stree	et, factory, office building, etc.		reet and Number or Ru	ral Route Number, City				
Div spital or hours afte neral Dir filled in	4 Homicide determined (Specify)			or Town, Sta	.te)					
To the Hospital within 24 hours: To the Funeral completely filled	29a. Certifier Check only 1 Certifying Physician: To the best of one) 2 Medical Examiner: On the basis of examiner:	xamination and/or investigat								
To To	29b. Signature and title of certifier	ed	29c. License number		29d. Date signed (Mor	nth, Day, Year)				
	Pote a - Pos	Der u	O.C.M.E.		July 14, 2008					
2	30. Name and address of person who completed cause of Patricia Aronica-Pollak MD. Assistant	f death (Item 23a) Medical Examiner	111 Penn Street, Baltimo	re, MD 21201						
State	31. Date filed (Month, Day, Year) 32. Regist	trar's Signature	40							
Registra	JUL 17 2008 Se	Circa St. figh	W.							

DHMH 17 Rev 1/2001 OCME 2006 1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney

Certificate of Death

2. Date of Death

23025

3. Time of Death

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 23026 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robin Kenee 8:50 A M JULY 2008 14. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE RUXTON OF PIKESVILLE PIKESVILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 💢 F Months 83 FRANCE 077-24-5895 03/07/1925 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventh process. 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State BALTIMORE 1 ☐ Yes 2 No PIKESVILLE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 SUDBROOK LANE 21208 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married □Yes 2NNo Yes, Give 1 ☐ Yes 2X No Specify WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MUTUAL OF NEW YORK OFFICE MANAGER 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RABINOVITCH SHAINDEL ပ FELIX 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NORA ZOLOTOROW / COUSIN 2903 FALLSTAFF RD., APT. 405 BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM MEM. PARK 7/16/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatur of Funeral S 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Ertel the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Ento the cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician the as IF FEMALE: use yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ō in the past 12 months? Day 5 Other (specify) 9 I Inknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Hospital or Attending Physician: The certificate 2 M No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🖼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 737573 14, 2003 death (Item 23a) (Type, Print) 30. Name and address of person who completed ause o 21136 Reistas MD 52 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

amend #10c Per HH G881 //1/08 H State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 23027 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2008 Ò /Medical Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner TOR mor 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🕩 Yrs Virginia 10 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore 1 Nes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? 21206 500 14. Race American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: BlAck 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RIVATE omEsti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Work ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 410. 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town. State 1 Burial 2 □ Cremation 3 ☐Removal from_State AURE 4 □ Dopation 5 □ Other (Specify) 21. Sign re of Funeral Service Licensee Jaused the death. Do not enter the mode of dying, such as cardiac or respirate Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final EMENTIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): SCVI Examiner Sequentially list conditions, if any leading to him detections. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician a Box 68760, Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a o. 9□Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 4 Unknown 2 No 3 Probably 1 Tyes 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform certificate 1 Division or Vital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3□ DOA ٩ this funeral 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Certification: 5 ☐ Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) larghern Words 1 881 Novendo rangens 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Rowle 17:08 M 4c. County of Death Anna /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner medical cente N/A 8. Date of Birth (Month, Dav. Year) 9. Birthplace (State or Foreign **Funeral** Min 1 □ M 2 🖫 F 216-54-4189 Maryland 59 Director Dec. 14.1948 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 No MD Baltimore Overlea Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 4307 Kenwood Avenue Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: "natural", or 1 ☐ Yes 2 No Specify Specify: White þ 3 ☐Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any Injury or other traumatic event, the Medical. once. 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Programer Computer Data 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Fisher Thomas Swayne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Victoria Topper-Daughter 4307 Kenwood Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/14/08 Metro Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, MD 21206 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Inter the diseas Immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebra removehage /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknowr been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 TYes 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate I 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Jo this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

Division or Vital Records, P.O. Box 68760, 24 hours after death e Funeral Director; within 2

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifie

e and addres

telain 31. Date filed (Month, Day,

of person

W

completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death

4b. City, Town, or Location of Death

GALTIMO RE
If Under 1 Year | If Under 24 Hrs. | 8
Months | Days | Hours | Min. |

JULY

Aug.

Date of Birth (Month, Day, Year)

8:00 PM

9. Birthplace (State or Foreign Country)
Maryland

2008

4c. County of Death

1932

Physician /Medical **Examiner**

Funeral

Director

Myrtle Ruth Schwab

AGNES

Social Security Number

213-32-0923

4a. Facility Name (If not institution, give street and number)

6. Sex

HOSPITAL

1 ☐ M 2 🔀 F

7. Age (In yrs. last birthday)

75

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

	Usual Residence of Decedent											
Ì	10a. State 10b. County		10c. City, To	own or Location							e City Limits ∕es 2 XNo	
ţ	Maryland Baltim	ore	C	atonsvi	11e					, , ,	- 2 ZANO	
rec	10e. Street and Number			10f.	1	0g. Citize	en of What Cou	untry?				
Ö	100 C H411+on Po	ad		21228					USA			
era	102 S. Hilltop Ro	12. Was Decedent 8	Ever in U.S.				pecify Yes or No-		4. Race - Amer Black, White		1,	
Ë	1 □ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ██	No				o Rican, etc.)					
Jy F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 X No	Specify:			Specify: Whi	LLe		
To Be Completed by Funeral Director	15. Decedent's E (Specify only highest gr.	ade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry			
ם	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Homem				Own Home				
ပိ	17. Father's Name (First, Middle, Last					18. Mother's Nan	ne (First, Middle,	Maiden S	Surname)			
Be	Harry Norman Col					Ruth	n N. Bau	er				
မ			17	Oh Mailing Addr	roce /Stract a	nd Number or Ri	ıral Boute Numbe	r City or	Town, State, 2	Zip Code)		
	19a. Informant's Name/Relationship (Type. Print) Harry Schwab Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip of the Schwab 102 S. Hilltop Road; Catonsville, Marylan										1220	
	Harry Schwab	Husbar				p Road;	Catonsv:		• Mary L ation - City or			
	20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 [Domoval from State	20b. Place ceme	e of Disposition (etery, crematory	or other place)	Date	200. L00	allon - Oily or	TOWIT, Stat	0	
	4 □ Donation 5 □ Other (Spec		Loude	n Park	Cemete	ry 7/16	5/2008	Ba1t	imore,	Mary	land	
	21. Signature of Funeral Service Lice	ensee		22. Name	e and Addres	of Facility St	rling A consvill nue; Cat	shton	n Schwa	b Wit	zke	
	Marke	1. Illen	1-21-	1630	Edmond	son Ave	nue; Cat	onsv	ille, M	D 212	228	
	23a, Part1. Enter the disease, or cor	mplications that cause	d the death. I	Do not enter the	mode of dying	, such as cardia	or respiratory ar	rest,			imate I Between	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition PROLYMPHOCYTIC LEUKEM)A										
	disease or condition resulting in death)				7 112	LEU	KEMIH			_2	(EAK)	
	resulting in death)	Due to (or as	a consequen	ice of):	7 01 A	0.7.0	STNDR	NME		.3	YFAR	
	Sequentially list conditions.	D. —			SILM	SIC	2 (MDIV	01116			1 CIIN	
je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that i	Due to (or as	a consequer	ice of):								
E	I triat iritiated events	c										
E	resulting in death) Last	Due to (or as	a consequer	ice of):								
ca		d										
edi											· · · · · · · · · · · · · · · · · · ·	
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			oio prognanov			2	23d. Date of de		Van	
cial	in the past 12 months?	4□Pregnant a	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							Day	Year	
ysi	9 Unknown	9□Unknown									_	
유	Part II. Other significant conditions	contributing to death	but not resulti	ng in the underlyi	ing cause give	n in Part I.	23e. Did t	obacco u	se contribute t	o the caus	e of death?	
ğ							1 🗆	Yes 2[□ No 3□ F	robably	4 🛣 Unknov	
ompleted by							04- 11/00		24b. Were a	utoney fine	linge availah	
읦	<u> </u>						24a. Was		prior to death?	completion	n of cause o	
							1□ Yes)	
e C	25. Was case referred to medical					26. Place of De	ath (Check only	опе)				
To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 X Inpat	tient 2 EF	R/Outpatient 3[DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Resi	idence	6 □Other (Sp	ecity)		
ᇣ	27. Manner of Death	28a. Date of In		8b. Time of Injury	28c. Injur Wor	y at	28d. Describe	how injur	y occurred			
<u>Ş</u> .	1 Natural 5 Pending 2 Accident investigat		ay rear	М		Yes 2 □ No						
Sa	3 Suicide 6 Could not	be 28e. Place of ir	njury - At hom	e, farm, street, fa	actory, office		28f. Location (Street an	d Number or F	Rural Route	Number,	
it.	4 ☐ Homicide determine	building, etc. (Specify) City or Town, Sta						mii, Jiale	2/			
27. Manner of Death 1 Natural 2 Accident 3 Sulcide 4 Homicide 29a. Certifier (Check only one) 29a. Certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. Manner of Death 1 Natural 2 Natu												
ica	(Check only 2 Medical Ex	aminer: On the basis	of examination	on and/or investig	ation, in my	pinion, death oc	curred at the time	, date an	d place, and di	ue to the ca	ause(s)	
Aed	one)	and mainers	and manner stated. 29c. License number					29d. Da	te signed (Moi	nth, Day, Y	ear)	
-	29b. Signature and title of certifier) Men.	ICAL DOCTOR P20805					JULY 12 2008				
		INITIDI	LAL	DOLIOK	1	AC 803	>	2	1-1 10	0	0	

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State

Registrar

KWAME

31. Date filed (Month, Day, Year)

JUL 1 7 2008

CATUN

AVE BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32 Hegistrar's Signature

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Reg. N	o. ८	U	U	0	4	J	U	J	(
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Physician
/Medical
Examiner

Funeral Director 28a-f show 23a or or items

other traumatic event, the Medical Exeminer must be notified at Pages 1 and 2 should be filed within 72 hours after Department of Health ar Important: If Item 27 is any injury or other trau once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, filled in by the f within 24 hours as

To the Funeral D

completely filled i

2. Date of Death DONALD HENRY **STEVENS** July 15 2008 11:30P 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Sar) | Win. | June 8, 1938 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, XX M 2 F New York 219-26-7443 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 🙀 🖠 o Director Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 611 Worcester Road 21286 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z X 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 XXIo White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Assilsant Director of Revenue 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Railroad Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Frank Stevens Madeleine Nauss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Catherine M Stevens 611 Worcester Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 KN Burial 2 Cremation 3 Removal from State New Cathedral Cemetery July 19,2008 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of FaciliMitchell-Wiedefeld Funeral Home Inc Sanature of Funeral rvilce Lice 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death Part 1. Enter the disea. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on Immediate Cause (Final COLIUBUSTOMA MULTFORME inonus disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6-DOther (Specify) WSFLC 1 Tes 2 Mo Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 😭 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JULY 16 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANCO 5 CHARLES W G7U/ N- CUS 70NSON NO 21204 GTUI N. CURRIES ST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

2008

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Shropshire 1207 AM Physician Joseph 9. Shrot 4a. Facility Name (If not institution, give street and num 2008 Juli 08 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimone Memoria Union If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Hours Min. 1 □ ₩ 2 □ F 412-56-2416 11.16.1937 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County 28a-f show ns 23a or 28a-f shorman 1 ☐¥es 2 ☐ No Baltimore W Director 10g. Citizen of What Country? 10e. Street and Number death with 91919 Funeral Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. ō Health and Mental Hygiene.
em 27 Is marked other than "natural", o þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ermadelle Archie Shrapshire, Sr. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. Kose Shropshire 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Degrial 2 ☐ Cremation 3 ☐ Removal from State 7.18.2001 Baltimore, MD Veryon C. Greene Feneral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Vaughn C. Leene 405 York Ad Bultimore, N

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4105 York Ad Baltimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 schemic gears **Physician** cardiomyopathy /Medical Due to (or as a consequence of): **Examiner** artem diseas Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nsequence of): Examine To the HospItal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit It y pertension

Due do (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed^a 2 🗆 No 2 No 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Maccident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AT 2438946-AS 2008 M.D. July 08, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lattenburg (Memorial Union State Charge par Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23032 008 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 11:15 A M · 2008 aro /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ratimore 1824 ambard 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Months Hours 1 □ M 2 □ F 220-76-1816 11.21.1946 AV Director 6 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Executiver quest be notified at 1 HYE'S 2 No Director MI altimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 91333 1824 Items 23a ombard Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 **②** If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 0 No Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify White 3 ☐ Widowed 4 ☐ Divorced 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Waitress 8+5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental H int: If Itam 27 is marked of selbert Conningham Ettie Grimett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1812 W. Pratt Street. Baltimore, MD 21223 ing Smith 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of Important: If It any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 7.16.2008 Battimore ML 1 4 ☐ Donation 5 ☐ Other (Specify) orraine Part 22. Name and Address of Facility Vaugna C. Green French Services 21. Signature of Funeral Service License . Theere Vaughn C. Sheere 4905 York had Balfimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York And Baltimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final CERVICAL CANCER METASTATIC years Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed physicien and s the burial-translt Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after de Funaral Diraci 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal To the Hosp within 24 ho To the Funs completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) MD D16354

Registrar

n

State

EW COLE

31. Date filed (Month, Day, Year)

900 CATON AVE BALTIMORE MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGNES

32 Registrar's Signature

2. Date of Death

	Physici /Medic	_	HILDA	M.	S	CHWART	'Z	JULY	13 ^{pay}	$2\overset{\text{Year}}{0}8$	3:59 P.™
Examiner			4a. Facility Name (If not institution, give			4b. City, Town, or Location of Death ABERDEEN			th 4c. County of D		
	Funeral Director		218-30-9357	7. Age (In y.		If Under 1 Year Months Days			, 1940	9. Birthp	place (State or Foreign ofto) YLAND
20	yland how		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loca	ition				1	0d. Inside City Limits
	he Mar 8a-f sl otified	ector	MD HARFOI	RD	ABERDE			r	40- 0''	514/L-1 O-	1 ☐ Yes 2X No
	with t	Dir	10e. Street and Number 83 VALLEY BOTTO	OM ROAD		10f. Zip Code 2100	1		10g. Citizen of U.S		itry?
	be filed within 72 hours after death with the Marylan Ital Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give			Hispanic Origin? (ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	0- 14. Ra	ace - Americ ack, White, cify: WH	etc.
-00030	2 hours atural' cal Ex		15. Decedent's Edu	Year or Dates:	16a. Decede	nt's Usual Occu	pation		16b. Kind of		
2 2	within 73 ene. than "na he Medi	Completed	(Specify only highest grad	College (1-4or 5+)	1		during most of wo		1		
7	filed wi Hygier other th	S	17. Father's Name (First, Middle, Last)	1 YR	PRODUC	CTION	COORDIN	ATOR ame (First, Middle			JBLISHING
and	lid be f lental I ked of	To Be	CHARLES WILLIAM	1 SCHAFER				A. HERO		imey	
ary	2 should be and Mental Is marked of aumatic ev	۲	19a. Informant's Name/Relationship (7)	vpe. Print)	19b. Mailing	Address (Stree	et and Number or F	Rural Route Numl	ber, City or Tow	n, State, Zip	Code)
∑	7.2 j		HARRY POLLAY (1		83 V	ALLEY	BOTTOM				21001
aitimor	permit. Pages 1 a Department of Hec Important: If Item any Injury or othe		20a. Method of Disposition 1 □ Burial 2 【Cremation 3 □ id □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License	Removal from State	22.	CREMAT Name and Addr	ORY 7-1	CZOROWS	KI FUN	MORE, IERAL	, MARYLAND HOME, PA
Ď	an me		Tolud 1/200	land						, MD	. 21222
Physiciar /Medica Examine			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a const, lence of): Approximate Interval Between Onset and Death Disease or condition								Approximate Interval Between Onset and Death
The law requires that the death conflicted he executed	eath certificate be executed attending physician and for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons c. Due to (or as a cons d.							
	00	ed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3 □E	Ectopic pregnan Other <i>(specify)</i>				Date of delive	ery Day Year
	w requires that the s been signed by the should be detache		Part II. Other significant conditions of	ntributing to death but not	resulting in the und	lerlying cause g	iven in Part I.		tobacco use co		the cause of death?
	The Is ate has page 2	Completed						24a. Was auto perl 1∐ Yes	s an 24l opsy formed? 2 No	b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of 2 \(\square\$ No
N II a	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		lo		eath (Check only			
5	this ald	<u>ا۔</u>	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2	2 ER/Outpatient 28b. Time of	OLI DOA		Home 5 Res	idence 6 C		fy)
0	ath. or: After th	ation	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	r) Injury	M 28c. Inju	ork? ⊒Yes 2 ⊒No				
DIVIS	pital or Attending Fours after death. eral Director: After filled in by the funer.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Sp.	at home, farm, stree ecify)	et, factory, office	•		(Street and Nur own, State)	nber or Rur	al Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical (29a. Certifier (Check only one) 1 Scertifying Phy 2 Medical Exam	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death nination and/or inve	occurred at the estigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s) and e, date and plac	manner as s	stated. to the cause(s)
	Totl withii Totl comp	M	29b. Signature and title of certifier	0.45		29c. Licer	nse number		29d. Date sign	ned (Month,	Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

Yeoin schendel

31. Date filed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

3d. Date of delivery Month Day Year se contribute to the cause of death? X No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ☐Other (Specify) occurred d Number or Rural Route Number, and manner as stated. 29d. Date signed (Month, Day, Year) 7-14-2008 9114 PhiladelphialD, Suite 300, PATO NO 21237

23033

State Registrar

D34758

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien 2 1 1 2

23031

		1	For State Registrar	State of Maryland		tificate of L			ag. No.	23034		
			1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	Dav Year	3. Time of Death		
	Physicia /Medic		ROSE SZY	MANSKI				JULY	15 2008	<u></u>		
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or			4c. County of Deat			
			7047 Eastbrook Social Security Number 6.S		at hiethday)	Eastwoo	If Under 24 Hrs.	8. Date of Birth	Baltimo	nplace (State or Foreign		
	Funeral		1	M 201 91	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb21	Year) Co	untry) sissippi		
	Director	215-05-5825 91 Tris. Feb21,								* *		
	yland		10a. State 10b. County	· ·	Town or Lo					10d. Inside City Limits 1 □XYes 2 □ No		
	e Ma la-f s	cto	Md.	В	altin	ore Cit	У		On China of Miles Co			
	or 28	Director	10e. Street and Number			10f. Zip Code	0.4		Og. Citizen of What Co	untry?		
	ath w		609 South Rose	Street 12. Was Decedent Ever in U.3	12 1	212		ecify Yes or No-	U.S.A.	rican Indian,		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "neturel; or Items 23a or 28a-f show aumetic event, the Maplical Examination as the notified a	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit			
15-0036	ges 1 and 2 should be filed within 72 hou to Health and Mental Hyglene. If item 27 is marked other than "neture or other traumetic event, It is Madical E	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing	16b. Kind of Business	Industry		
2121	within ene. then	m C	Elementary/Secondary (0-12)	College (1-4or 5+)		ne Maker			Own Hom	ne		
d 2	filed with Hygiene. other there		17. Father's Name (First, Middle, Last)	1101	ic Hange		e (First, Middle,	Maiden Sumame)			
lan	id be lental ked c	To Be	James Kleinsm	ith				Kiele				
Maryland	should be and Mental is marked o aumetic sve		19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Numbe	r. City or Town, State.	Zip Code)		
	1 and 2 Health a em 27 ls		Theresa Kaczyn						Itimore, M	Town State		
ore	of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 D	Removal from State		sition (Name of matory or other plac	' <u>.</u>	Date	20c. Location - City or			
Ē	Pa Fig.		1 4 □ Donation 5 □ Other (Special	(y) St		anislaus				Maryland		
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facilitikaczorowski Funeral Home, F 1201 Dundalk Ave. Baltimore, Md. 21222									
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not en	ter the mode of dyin	ig, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death		
	Pnysician		Immediate Cause (Final disease or condition CHRONIC OBSTRUCTIVE PULMONARY DISEASE									
	/Medical Examiner		resulting in death) Due to (or as a consequence of):									
	Lxammer	ايا	Sequentially list conditions,	b. Due to for as a consequence	ience of):							
V	ed sit	nlne	Cause. Enter Underlying Cause (Disease or injury									
-	xecut and	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	uence of):							
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687		edical							-			
O. Box	death cert e attending d for use	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d. Date of de Month	elivery Day Year		
Φ.	that the	y Ph	Part II. Other significant conditions					23e. Did to	obacco use contribute t	to the cause of death?		
rds	The law requires that the ate has been signed by the page 2 should be detache	q p	CONCESTIVE HEART FAILURE HYPERTENSION, 10 Yes							robably 4 Unknown		
Division of Vital Records,		Completed by Physici	ESOPHAGEAL	UNCER				24a. Was autor perfo 1 Yes	osy prior to ormed? death?	utopsy findings available completion of cause of s 2 \(\sum \) No		
ita	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?					th Check on c	one Daug!	ater s		
× ×	S 5	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2			4 Nulsing I		dence Other (Sp	ecify) Home		
n o	Jing Ph J. After th funeral	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? M 1 Yes 2 No							now injury coodco			
Sio	Attending r death. sctor: After by the fune	icat	2 Accident investigati	be see Place of Injury - At h	ome. farm. s			28f. Location (Street and Number or F	Rural Route Number,		
Div	는 를 다	Certification:	4 ☐ Homicide determine	building, etc. (Special		.,,		City or To	wn, State)			
9 % 9 8 9						, and due to the irred at the time,	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)					
	To the Hose within 24 ho To the Fune completely f	Med	29b. Signature and title of certifier	A Stateo.		29c. Licen:	se number		29d. Date signed (Mor	nth, Day, Year)		
	F 3 F 8		Donal 1	Goodh N	0	71.	2032		JULY 15	2008		
	į		30. Name and address of person wh	o completed cause of death (Ite	n 23a) (Type							
	10		JEAN, FER HAVINS	HI 5505 Ho	PKINS	BAYVIEN	CIRCLE	BALTI	MORE M	D 21224		
		ate	31. Date filed (Month, Day, Year)	32 Pegistrar's Sign	ature	berte						
	Regist	-	1111 1 7	71111X 1 5"5 25"x 26" x 2	d	Control of the Contro						

State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician PAUL MELVIN THOMAS JULY 2008 8:07 AM 14, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 5935 BENTON HEIGHTS AVE BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea JUNE 27, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 ∏ M 2 ☐ F 1938 70 Director 219-26-7618 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County sa or 28a-f show t be notified at 1 Yes 2 No Directo BALTIMORE N/AMD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ms 23a 21206 USA 5935 BENTON HEIGHTS AVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed er than "natur , the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene, tem 27 is marked other than US POSTAL SERVICE LETTER CARRIER 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLARA KERN ROBERT THOMAS 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5935 BENTON HEIGHTS AVE BALTIMORE, MD 21206 MARY THOMAS-WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 7/16/08 BALTIMORE, MD METRO CREMATORY 4 □ Donation 5 □ Other (Specify) 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 4 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a conset Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform cate ha 1∐ Yes 2 N this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | № 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 Yes 2 Accident hours efter death Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funeral Directory filled in by 4 Homicide 29a. Certifier 1 SertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie cause of death (Item 23a) (Type, Print) 30. Name and address of person who Day, Year) 32 Registrar's Signature 31. Date filed (Month State 2008 Registrar

			partment of Health and M <i>ertificate of Death</i>	lental Hygiene	2008 23036			
		Registrar	2. Date of Death	3. Time of Death				
Physic	ician	Decedent's Name (First, Middle, Last)	July 16, 2	2008 Year 4:46 A. M				
/Med		Robert J. M. Wilson 4a. Facility Name (If not institution, give street and number)		c. County of Death				
Exami	ner	Charlestown Care Center	4b. City, Town, or Location of Death Catonsville	1	Baltimore			
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)			
Funeral Director		074-12-0865 1⊠M 2□F 88 Yrs	Months Days Hours Min.	Feb. 8, 19	20 New York			
	-	Usual Residence of Decedent			10d. Inside City Limits			
how		10a. State 10b. County 10c. City, Town or	Location		1 ☐ Yes 2 █3No			
e Ma 3a-f s	cto	Maryland Baltimore Catons		10g C	itizen of What Country?			
or 28	Director	10e. Street and Number	10f. Zip Code 21228		USA			
ath w	<u>ra</u>	717 Maiden Choice Lane T-25			14. Race - American Indian,			
be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Eximiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Widowed 4 □ Divorced 1 □ Widowed 4 □ Divorced 12. Was Decement 2 verificolos.	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White, etc. Specify: White			
rithin 72 hours af ne. han "natural", or e Medical Ex mi	Completed b	162 D	ecedent's Usual Occupation Give kind of work done during most of work te. DO NOT use retired)	king 16b.	Kind of Business/Industry			
ithin ne.	lg m	Elementary/Secondary (0-12) College (1-4or 5+)	Finance		vestment Company			
F G G G		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide	en Surname)			
to be find the find t	Be	Albert J. M. Wilson	Charlot	te Kaye				
2 should be filed w and Mental Hygie lis marked other traumatic event, th	ြင		lailing Address (Street and Number or Ru	ıral Route Number, City	l Route Number, City or Town, State, Zip Code)			
INCL YICLD nd 2 should be file thith and Mentai Hy 27 Is marked oth traumatic eveni			7 Chattolanee Hill	Road; Owin	gs Mills, MD 21117			
Pa a 3			isposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State			
ages ent of ft: If i		1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State		/2008 Cat	consville, MD			
DallIIIOI e, permit. Pages 1 ar Department of Hea Important: If item; any injury or other	ŭ	21. Signature of Funeral Service Licensee	On Name and Address of English	erling Ash	ton Schwab Witzke			
Per Jen	5	12 11 11 MO1490	Funeral Home of Ca 1630 Edmondson Ave	nue; Caton	sville, MD 21228			
1 - 1		23a. Part1. Enter the disease, or complications that caused the death. Do no	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death			
Physician	,	Immediate Cause (Final disease or condition	rent, 9		Offset and Death			
/Medica		resulting in death) Due to (or as a consequence of)						
Examine	r .	Sequentially list conditions b.						
· • • #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):						
cate be executed physician and the burial-transit	am							
8 / 6U, ate be exc hysician a the burial-		Due to (or as a consequence on).						
cate I	dical	d						
I Records, P.O. Box 62 The law requires that the death certifics the has been signed by the attending phoage 2 should be detached for use as the second of the second o	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		23d. Date of delivery Month Day Year				
T. That the day t etach	Phy	Part II. Other significant conditions contributing to death but not resulting in	23e. Did tobacc	23e. Did tobacco use contribute to the cause of death?				
dS, ires the signer	2	Takin Salar Significance	1 ☐ Yes	2 No 3 Probably 4 Unknown				
cord w require been significantly should b	Completed			24a, Was an	24b. Were autopsy findings available			
tectaw e taw has t	Jan.			autopsy performed				
VITAI F siclan: Th certificate rector, pag			26 Place of De	1□ Yes 2□ eath (Check only one)	Ho 1 □Yes 2 □ No			
VIT siclar certif rector	Be		Other	Home 5 ☐ Residence	e 6 ☐Other (Specify)			
OF Phys rrthis eral di	<u></u> 은	28b Ti	me of 28c. Injury at	28d. Describe how it				
VISION OF VITA Attending Physician: r death. ector: After this certifica by the funeral director.	tion	1 Natural 5 Pending (Month, Day Year) In 2 Accident investigation	jury Work? M 1 ☐ Yes 2 ☐ No					
Division or VItal Records, P.O. for Attending Physician: The law requires that the drafter death. Director: After this certificate has been signed by the dine tyne funeral director, page 2 should be detached.	Certification:	3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)	m, street, factory, office	28f. Location (Street City or Town, S	t and Number or Rural Route Number, tate)			
Division or Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical Ce		death occurred at the time, date and place for investigation, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)			
To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)			
20.41								
	State istrar	THE PROPERTY OF THE PROPERTY O	porti					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 02:17AM **Physician** Walton 2008 ammy Jule /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Manyland medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Magnth 6 Day, 1970 Massycand 1 □ M 2 💢 F Director Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 No Cecil Cecilton Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code th and Mental Hygiene. 7 is marked other than "natural", or items 23a or trammatic event, the Medical Examiner must be r 21913 218 West Main Street United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or then any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify: Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Natural Health Technician Health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie B. Walton Sharon A. Ingram ပ 19a. Informant's Name/Relationship (Type. Print) Willie B. Walton/ Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 West Main Street, Cecilton, Maryland 21913 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gardens 07/16/2008 Bel Air, Maryland 22. Name and Address of Facility Havre de Grace, Maryland 21078 Zellman Funeral Home, P.A. 123 S. Washington St. 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or commencations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Desmoplastic 1 month Physician /Medical Due to (or as a consequence of): Examiner 1 week Reva Se mentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. • Funeral Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar (Check only one)

29b. Signature and title of certifier

Silhan

egistrar's Signature 31. Date filed (Month, Day, Year)

South

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Greene Street Baltimore, Maryland

29d. Date signed (Month, Day, Year)

08-05372 John Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1350 hrs Medical Examiner July 13, 2008 4c. County of Death 4b. City, Town, or Location of Death Sinai Hospital **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Country) Hours Min. Director Usual Residence of Deceden 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No MOM Pages 1 and 2 should be filed within 72 hours after death with the Maryland 23a or 28a-notified at 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces' Never Marned Yes Yes 2 No specify: Widowed 4 Divorced If Yes, Give Yeer marked other than "natural", þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Indust Completed during most of working life. DO NOT use retired) MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname nent of Health and Mental H int: If item 27 is marked or r other traumatic event. H 19b. Mailing Address 20b. Place of Disposition (Name of cemetery 20c 20a. Method of Disposition Baltimore, 2 Cremation tant: Donation 5 Other Specify Physician disease, or complications that caused the death failure. List only one cause on each line Between Onset and 'Medical Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner If any leading to immediat Due to for as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED attending physician or use as the burial law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte be detached for u 1 Yes 2 No 9 Unknown Unknown o Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, page 2 should has been 24a, Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of death? Yes 2 V No 2 No Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: Other₄ Nursing Home 5 this Inpatient 2 V ER/Outpatient 3 DOA Residence 6 2 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Yes 2 Pending 2 Accident Investigation by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E July 14, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registra

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 2<u>008</u> **Physician** 2:15 David Edwin Williams July 15, /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Lutherville Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral XX**M 2□ F Months Days 298-20-0496 80 Director Dec. 3, 1927 Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Wedleal Evariner rust be notified at 1 TYes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5912 Glenkirk Road 21239 Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ ★ Ses 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married XX Married Maryland 21215-0036 1 ∐Yes **∑X**No Completed by Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Department of Health and Mential Hygiene Important: If item 27 Is marked other than any injury or other traumatic event, the Maone. College (1-4or 5+) E.L. Klock Company Repairman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Ruth Kirk ဂ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (WIFE) 5912 Glenkirk Road, Baltimore, MD Joyce Williams 15, Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2XX remation 3 Removal from State 4 Donation 5 Dother (Specify) 07/19/2008 Metro Crematory Catonsville, MD 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21. Sign were of Funeral Service Licensee 23a. Part 1. Expert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3631 Falls Road, Baltimore, MD 21211 Approximate Interval Between Onset and Death Immediate Cause (Final Physician ESOPHAGEAL CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-transit and Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) this certificate has been signed by the all director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2X No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 K Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 2 Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

173725

29d. Date signed (Month, Day, Year)

6108

			1 - For State of Maryland / Depa	rtment of Health and Ment	tal Hygiene Reg. No. 2008 23040
	Physici /Medic Examin	cal	1. Decedent's Name (First, Middle, Last) Margaret Ann Wilgis	4b. City, Town, or Location of Death	ate of Death fonth Day Year 3. Time of Death School AM 4c. County of Death
	Funeral Director		Union Memorial Hospital 5. Social Security Number 6. Sex 1 M 2XX 68 Yrs.	Baltimore If Under 1 Year If Under 24 Hrs. 8. D Months Days Hours Min. (A	N/A ate of Birth Month, Day, Year) 27, 1939 N/A 9. Birthplace (State or Foreign Country) Maryland
	D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc		10d. Inside City Limits
	r 28a-f s	irecto	MD N/A B	altimore 10f. Zip Code	XXYes 2 ☐ No 10g. Citizen of What Country?
	h with	a D	2633 Hampden Avenue	21211	U.S.A.
136	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, if a Redical Examination in the indifficult at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1 □ Yes 2√√No	In as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican ☐ Yes XXNo Specify:	Yes or No- h, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
1215-0036	/ithin 72 ine. han "na	Completed	(Specify only highest grade completed) (Give kife. D College (1-4or 5+)	ent's Usual Occupation ind of work done during most of working O NOT use retired)	16b. Kind of Business/Industry
7	iled w Hygie ther th	ပ္ပ	12th Sa 17. Father's Name (First, Middle, Last)	lesperson	Copy Cat Printing st, Middle, Maiden Surname)
ryiand	2 should be filed w h and Mental Hygie r is marked other t raumatic event, In	To Be	Albert Schultz	Marie De I	Frank
e, Mar	and 2 sh fealth and m 27 is r her traur		Francis Wilgis (Husband) 2633	Hampden Avenue, Bal	
baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic en once.			Cemetery 07/19/2	
Ball	permit. Departi Import any Inj once.		21. Signature of Fineral Service Licensee 22.	Name and Address of Facility Burgee-Henss-Seitz I 3631 Falls Road, I	Funeral Home, Inc. Baltimore, Maryland 21211
	Physician /Medical Examiner	Examiner	23a. Part 1. Either the diseast, or complicator's that caused the death. Do not ente shock, or eart failure. List only one cause on each line.	r the mode of dying, such as cardiac or res	piratory arrest, Approximate Interval Between
>'00/90	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical	resulting in death) Last Due to (or as a consequence of): d		
.O. Box	the death ce by the attendi ached for use	Physician/Med	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
cords, r	equires that en signed I suld be det	þ	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ★ Unknown
al Reco	t: The law re icate has be ; page 2 sho	Completed	Hyperlipidemia		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
N Ea	sician certif rector	Be	25. Was case referred to medical examiner?	26. Place of Death (Che	
	J Phy:	7:10	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 DER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred
SION	nding ath. r: Afte e fun	atio	1 Matural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)
	ne Hospit n 24 hour ne Funera	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death Medical Examiner: On the basis of examination and/or invand manner stated.		
	To the within	M	29b. Signature and trig of certifier OWEDD M D	29c. License number 00055459	29d. Date signed (Month, Day, Year) July 14, 2008
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, P 31. Date filed (Month, Day, Yeal) 32. Registrar's Signature	(c) MD Unic	n Memorial Hospital
	Sta Registr		31. Date filed (Month, Day, Yeal) JUL 1 7 2008	2	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 23041 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Renate Margaret Zuck **10:4**0₽[™] July 11 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Fairfield Nursing Home Crownsville Anne Arundel Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2**X**F Months Days Dec. 19, 1939 Germany 113**-**32**-**7275 10c. City, Town or Location 10h. County 10d. Inside City Limits Anne Arundel Crownsville 1 ∐Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1454 Fairfield Loop Rd. USA 21032 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Karl Metzger Katrina Millianna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Scott, daughter 7142 Ohio Ave. Hanover, MD. 21076 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Meadowridge Memorial Park 07-16-08 1 Burial 2 □ Cremation 3 □ Removal from State Elkridge, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 23a. Jort1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death many years Due to (or as a consequence of): many wently Le cubi hús Due to for as a consequence off: Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

by Funeral

Completed

Funeral

Director

iral", or Items 23a or 28a-f show Examiner must be notified at

2 should be filed within 72 hours after death with and Mental Hygiene. Its marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be raumatic event.

1 and 2 should be Health and Mental

item 27 I

permit. Pages 1
Department of H
Important: If ite
any injury or ott

Baltimore, Maryland 21215-0036

Box 68760.

Records, P.O.

Division or Vital

Examine Physician/Medical þ Completed Be P

attending physician and for use as the bunal-tran signed by the a d be detached f certificate has After this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Certification:

Medical

Sequentially list conditions, if any, reading to initinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural
2 Accident (Month, Day Year) Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 12, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mirza Mohammed Nusairee 1401 Madison Pk. Suite#100 Glen Burnie MD 21061

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) a & sparks

			1 - For State Registrar	State of M	laryland /		artment o			nd Me	ental H	ygiene Reg. No.	008	23042
	Physici /Medic		1. Decedent's Name (First, Middle, La	AI	VEY					-	2. Date of D Month	eath Day	2000	3. Time of Death 345 A M
	Examin		4a. Eacility Name (If not institution, gir	re street and number)		4b. City, Too	wn, or L	ocation of	Death		4c.	County of Dea	th
Ī	Funeral Director		5. Social Security Number 220–28–6030	Sex 7. A 1 □ M 2 ☑ F	ge (In yrs. last	birthday) Yrs.			If Under 2 Hours	Min.	B. Date of B (Month, I	irth Day, Year)	C	thplace (State or Foreign ountry) rginia
	_		Usuel Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation				lay 10	,, 1,,,,		10d. Inside City Limits
	e Mary 3a-f shi	ctor	MD Talt	ot	E	asto	n							1 ☐ Yes 2 No
	with th	Funeral Director	10e. Street and Number				10f. Zip Co	ode 2160	1.1			10g. Citiz	en of What C	ountry?
	ms 23	era	205 Tred Avon A	12. Was Deceden	t Ever in U.S.	13.	Was Deceden f Yes, specify			in? (Spec	ify Yes or N	10- 1	4. Race - Am	
326	urs after o		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	No		fYes, specify 1☐ Yes 2☐		Mexican, Specify:	, Puerto H	ican, etc.)		Black, Whi	White
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show aumatic event. The Medical Exercitive must be notified at	Completed by	15. Decedent's E (Specify only highest gi			5a. Deced (Give lite.	dent's Usual C kind of work o DO NOT use i	Occupati done dui retired)	on ring most	of working	g	16b. Kir	d of Business	/Industry
7	ad witi	Com	5			C	ashier						ocery	Store
Maryland	d be filed antal Hyg ced othe c event.	Be	17. Father's Name (First, Middle, Las James King	t)				}			(First, Midd. Boyer	le, Maiden	Sumame)	
ary	as 1 and 2 should be the alth and Ment Health and Ment Hem 27 is markecrotother traumatice	P_	19a. Informant's Name/Relationship	(Type, Print)			ng Address (S	itreet an	d Numbe	r or Rural	Route Num			
	P S D =		Lester Bell/Son 20a. Method of Disposition				1 Silve				Le, Lu	-	D 206	
altimore,	Pages 1 nent of H int: if fite iry or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Spec		9		sition (Name natory or othe ethodi:			/3/20			ah,Mar	
alt	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		21. Signature of Funeral Service Lice	nsee M009	45	22	Name and A	Address	of Facility	FIINI	DAT I	IOME I	Α .	yzune
n	40 F 9 9		Mars C.	Chut			211 St	. Ma	ry's	Ave	-La-I	lata,	MD 20	646 Approximate
	Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a		M	er the mode of	d 17(such as o	n Fon	respiratory	arrest,		Interval Between Onset and Death
	/Medical Examiner		- 1		s a consequenc	ce of):								
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unuerlying Cause (Disease or injury	b. Due to (or a	s a consequenc	ce of):								
3760,	certificate be executed ding physician and use as the burial-transit	icai Exar	that initiated events resulting in death) Last	C. Due to (or a	s a consequenc	ce of):								
õ	tificate ng phys as the			u.			-							
O. Box	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Petal dea at time of death	ath 3	Ectopic pregi Other (speci						3d. Date of de Month	elivery Day Year
ecords, P.	as the gned	by	Part II. Other significant conditions	contributing to death	but not resulting	g in the u	nderlying caus	se given	in Part I.			tobacco u		to the cause of death? Probably 4 □Unknown
r	The ate h page	Completed										topsy form <u>ed</u> ?	24b. Were a prior to death?	
VItal	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other	-		(Check only			
0	Phys this ral di	n: To	1 Yes 2 No 27. Manmer of Death	1 ∐ Inpat	ury 28t	Outpatier		. Injury a	4 L X (101		ie 5 ☐ Re 8d. Describ		i □Other (Sp occurred	ecify)
Sion	or Attending Fifter death. Director: After in by the funer	catio	1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not		ay rear)	Injury	М		s 2 🗆 t					
DIVISION	al or Attends after death i Director: ad in by the	Certification:	3 Suicide 6 Could not determined	28e. Place of It	njury - At home etc. <i>(Specify)</i>	, farm, str	eet, factory, o	office		2		_(Street and own, State		Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical (hysician: To the bes miner: On the basis and manner s	of examination									
	To the To the comp	W	29b. Signature and title of certifier	John D	isll,	0	29c. L	icense i	number 0599	43		29d. Dat		nth. Day, Year)
5	812		30. Name and address of person who	completed cause of	death (Item 23)	a) (Type.	Print)	5	vite	30	7 ~	espr	inster	mo 21157
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 2	2008 32. Regis	TGS S trar's Signature	K A	barle							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	d is	4	1 - For State Registrar	e of Maryland		rtment of H tificate of £		ientai Hyg	giene Reg. No. 2	800	23043
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	F	ARR	EDON	DO	2. Date of Dea Month	Day	Year ZOOF	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and	d number)		4b. City, Town, or	Location of Death		4c. Cou	inty of Death	
			Washington Adventist Hosp	ital		Takoma	Park			Monte	gomery
П	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	h V Vear		ace (State or Foreign
	Director		577-72-2422 15km 2	F 85	Yrs.	Worth's Days	Hours Will.	June 21			
	D.		Usual Residence of Decedent								
	how	_	10a. State 10b. County	10c. City,	Town or Loc	cation				10	ld. Inside City Limits
	a-f s	cto	Maryland Montgome	erv	Si	lver Spri	nα				1 □Yes 2 🙀 No
	h the	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Count	ry?
	h wit		11361 Columbia Pike	. #812		2	0904		US	A	
	ms 2	Funeral	11. Marital Status 12. Was I	Decedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar		ecify Yes or No-		Race - America	
38	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, if a Modical Examination or culfind at	by Fu	1 ☐ Never Married 2 ★ Married 1 ☐ Y	d Forces? es 2∳ No , Give or Dates:		Yes, specify Cubar		uvian etc.)		Black, White, e e <i>cify:</i>	White
ŏ	2 hou	ed	15. Decedent's Education			lent's Usual Occupa			16b. Kind o	f Business/Ind	ustry
12	in 72	Completed	15. Decedent's Education (Specify only highest grade comple		(Give I life. D	kind of work done d OO NOT use retired)	uring most of worki	ng			
212	with jiene r tha	E	Elementary/Secondary (0-12) College	ge (1-4or 5+)	Pre	ess Opera	tor		Dr	intina	
ס	filed Hyg Sthel		17. Father's Name (First, Middle, Last)		110		18. Mother's Name	(First, Middle,			
au	should be filed vind Mental Hygie marked other timatic event, In	9 Be	Jose L. Arredondo				Teresa	T.i			
2	should I and Men s marke umatic	မ	19a. Informant's Name/Relationship (Type. Print)		19h Mailin	g Address (Street a			er City or To	wn State 7in	Code)
Z	12 ha	- 4	Elvira Arias/Daughter	1		agbark Co					0000)
a) O	s 1 and f Health item 27 other to		20a. Method of Disposition					Date		on - City or Tov	vn State
ਨੂ	ges nt of if ite		1 ☐ Burial 2√2 Cremation 3 ☐ Removal for	rom State		sition (Name of attory or other place	i .J11	1y 4	ZOC. LOCALI	on ony or roa	vii, Glate
<u>=</u>	: Pa tmer tant: jury		4 ☐ Donation 5 ☐ Other (Specify)	Met		tan Crema	atory 2	8008	Alexa	ndria,	Virginia
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licensee	nsu	- Fr	Name and Address cancis J. O Univers	s of Facility Collins sity Blvd	Funeral	Home	Inc. Spring	, MD 20901
	Physician and Medical Examiner By physician and physician and street purial-transit as the purial-transit as	edical Examiner	Sequentially list conditions, if any, leading to immisurate cause. Enter Underlying Cause (Disease or injury that initiated events	e to (or as a conseque to (or as a conseque to (or as a conseque	ence of):	AOR	TIC	ANE	ORY	S/1	Onset and Death
P.O. Box 68	the death certi y the attending ched for use a	Physician/Mec	1 1 1 1 1 1 1 1 1 1	, outcome of pregnan Live birth 2 ☐ Fetal or Pregnant at time of de Jnknown	death 3□ ath 5□	Ectopic pregnancy					Day Year
ŝ	requires that neen signed b	þ	Part II. Other significant conditions contributing	to death but not result	ing in the un	iderlying cause give	n in Part I.				e cause of death?
2	pluo bluo	ted						101	res 2 🔲 N	lo 3∏ Proba	ably 4 Unknown
Hecords,	slcian: The law i certificate has b irector, page 2 sh	ompleted						24a. Was autop perfo 1 □ Yes	rmed?	4b. Were autop prior to con death? 1 ☐ Yes	osy findings available inpletion of cause of
<u>g</u>	rtifice tor, p	BeC	25. Was case referred to medical				26. Place of Death				
>	yslc is ce direc	0	examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 🗶 🗏	R/Outpatien	t 3 DOA Othe				Other (Snecifi	·)
0	I or Attending Physician: after death. Director: After this certific d in by the funeral director; I	\vdash	27. Manner of Death 28a. I	Date of Injury 2	28b. Time of	28c. Injury	at	28d. Describe			·
0	th.: Aft	Certification:	1 Natural 5 □ Pending (2 □ Accident investigation	Month, Day, Year)	Injury	Work' M 1 □ Y	? ′es 2 □ No				
<u>s</u>	Atte	Ę	3 ☐ Suicide 6 ☐ Could not be	lace of Injury - At hom	ne, farm, stre	et, factory, office		28f. Location (S	Street and N	umber or Rura	Route Number,
UIVISION	afte Dire	erti	4 Homicide determined	uilding, etc. (Specify)				City or Tov	vn, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) Wedical Examiner: On to and	the best of my know he basis of examination	ledge, death on and/or inv	occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) an date and pla	d manner as stace, and due to	ated. the cause(s)
	ithin o the	Mec	29b. Signature and title of certifier	- Stated	-	29c. License	number		29d. Date si	gned (Month, I	Day, Year)
	FSF8			-		Dr.	55510			6/2-	DANG
	3(5)		'///	\mathcal{D}		100	20110		1:1-	0/00	1/2000
			30. Name and address of person who completed ROSS SWITTLE				ADVEN	1257	HOSP.	TAK	DIVIA PARK
	Sta Registra	_		2. Registrar's Signatu		\$0					

8-04992		Please Type or Print i	n Black Inde	lible Ink. E	nsure All Copie	s Are Legib	ole.	
ictor Hugo Lazaro		_			th and Mental H	ygiene	200	08 2304
	Re	For State gistrar	Certific	cate of Deat	n	Reg. I	No. 200	3. Time of Death
Physician/		Decedent's Name (First, Middle,Last) Victor Hugo Laz	aro Agu	stin		Month Da June 28, 200	ay Year	1010 hrs
Medical Examine ^^		a. Facility Name (if not institution, give street and r			own, or Location of Death		4c. County of Death	1
Cer	48	5119 Flintridge Drive	uniber)		over Hills		Prince George	e's
	5	Social Security Number 6. Sex	7. Age (In yrs. last b	pirthday) If Und	er 1 Year If Under 24Hrs	. 8. Date of Birth(N	MM/DD/YYYY) 9. Bit	thplace (State or
Funeral Director		213-25-8388 1 M 2 F	41	Yrs. Month	s Days Hours Min	Jan.5,	.1967 Foreign	onGuatemala ountry)
Bilostal	_	sual Residence of Decedent		115.	^	,		
any		Da. State 10b. County	10c. City, Tov	vn or Location			•	10d. Inside City Limits
*		MD Prince Georg	e's La	ndover F	Hills			1 Yes 2 X No
Maryland 28a-f show d at once.	3 1	De. Street and Number		10f. Zip	Code	10g.	Citizen of What Cou	intry?
the Maryland a or 28a-f sh tified at one	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	5119 Flintridge Dri	ve		20784		Guatema	la
			ecedent Ever in U.S.	13. Was Deced	ent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,
r death with or items 23	<u>₽</u> .	Never Married 2 Married Armed	Forces?	If Yes, speci	fy Cuban, Mexican, Puerto Guato	emalan		ite
5		Widowed 4 Divorced If Yes, Give Y	ear	1 X Yes 2			Specify:	
atural"		15. Decedent's Education (Specify only highest g	ade completed) 16		Occupation (Give kind of orking life. DO NOT use re		6b. Kind of Business	Industry Ukn
72 ha		Elomontally (- 1 =)	(1-4 or 5+)			UKII		
21215-0036 Juld be filed within 72 hourn it Mental Hygiene marked ofter than "nature event, the Medical Example For Pro Pro Commission for Pro Commission for Pro Commission for Pro Pro Commission for Pro Pro Commission for Pro Pro Pro Pro Pro Pro Pro Pro Pro P	ĒL	6			40 Mathera Nam	e (First, Middle, Ma	iden Surname)	
5-0 iled v Hygir filed to		7. Father's Name (First, Middle, Last)						mi o
121 d be fil lental H arked event,		Juan Francisco Laz 9a. Informant's Name/Relationship (Type, Print)	aro	19h Mailing Addres	s (Street and Number or		n Grego er, City or Town, Sta	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene antierit fitten 27 is marked other than "natural" or other traumatic event, the Medical Examine To Be Compilated by	- 1	Ana Osorio/Friend	ï		th Place		ville,Ma	1.0
, MD and 2 sho salth and em 27 is raumati	- 1	Oa. Method of Disposition		ce of Disposition (Na	me of cemetery,	Date	20c. Location - City of	or Town, State
Ore of Ho If it		1 X Burial 2 Cremation 3 Remova	I from State Geffer	ata i on Gew	etery 7/0	07/2008	Guatem	s Peten,
Fim Pag		4 Donation 5 Other Specify:	San	Luis Pe				
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med To Baltimore.		21. Sign au en Funeral Service Licersee		PHILII	Address of Facility D. RINALD	I FUNERA	AL SERVI	CE,P.A.
	+	23a, Part I. Enter the disease, or complications that	t caused the death. Do	not enter the mode	of dying, such as cardiac	or respiratory arres	t, shock, or heart	pproximate Interva
Physician → /Medical		failure. List only one cause on each line.						Between Onset and Death
xaminer		Immediate Cause (Final disease a. Cirrhosis	s a consequence of):					
		h	,					
	<u></u>	ally, roughly to mini-	s a consequence of):					
	E۱	cause. Enter Underlyin Cause (Disease or injury that initiated	s a consequence of):					
h = 1	֡׀֟֟	events resulting in death) Last Due to (or a						
execu	- g	UNPENDED AMENDE	D					_
. 50, te be te be ysicia	an/Medi		es, outcome of pregna	ncy			23d. Date of deliv	ery
Box 68760, c death certificate be the attending physicied for use as the burned.	[]	3b. Was decedent pregnant in the	ve birth	2 Fetal deat	h 3 Ectopic preg	nancy	Month	Day Year
th cer th cer r use	20	4 Pr	egnant at time of deatl	h 5 Other (Sp	pecify)			9.6
Bo te dea the a	Physici		nknown	ultime in the underlyi	ng cause given in Part I.	23e, Did tob	acco use contribute	to the cause of death?
cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	S	Part II. Other significant conditions contributing	ig to death but not rest	uning in the underly.	ng cacco green are	1 Yes	2 V No 3 F	robably 4 Unknown
S, F.						24a. Was a		autopsy findings available
cords law requires been bas been 2 should	흶					autops perform	y prior	to completion of cause of ?
Reco	Completed					1 ✔ Yes 2		Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requir is after death. "al Director: After this certificate has been s leed in by the funeral director, page 2 should the funeral director, page 2 should he	Be	25. Was case referred to medical			26.Place of Death (Che			
Vit; hysici this c	2	examiner? 1 Yes 2 No Hospital: 1		R/Outpatient 3	,			her: Scene
J Of Jing Ph	=[Pate of Injury lonth, Day,Year)	28b. Time of Injury	28c. Injury at Work?	280. Describe fi	ow injury occurred	
ion trendi leath. tor:	<u>a</u>	1 Natural 5 Pending 2 Accident Investigation				OOF Leasties (C	treat and Number of	Rural Route Number, City
ViS or At Office Direc	흹	3 Suicide 6 Could not be 28e.		ne, farm, street, facto	ory, office building, etc.	or Town, St		Rural Route Number, Ony
Division At the control of the contr	Certification:	4 Homicide determined (Spe				<u> </u>		
e Hos 124 h e Fun etely		29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the ba	best of my knowledge	e, death occurred at	the time, date and place, a my opinion, death occurre	and due to the caused at the time, date a	e(s) and manner as s and place, and due t	o the cause(s)
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director.	Medical	and mani	er stated.		29c. License number		29d. Date signed	
- 1/	Σ	29b. Signature and title of certifier	4.0		O.C.M.E.		June 29, 2008	
		Mayoute Une 45h	ell		U.U.IVI.E.		25, 25,	
		30. Name and address of person who completed			Street, Baltimore, M	D 21201		
			Medical Examine		Jucet, Dalumore, IVI			
Sta	ate	31. Date filed (Month, Day, Year) 2008	Registrar's Signatur	Back	7			
Registi	C.U	002 0 0 0000	7000	The same of the sa				

			_ For	State of Ma	ryland / l	Departr	ment of H	lealth and N	lental Hy	giene		
			1 - State Registrar			Certif	icate of l	Death		Reg. No. 2	ากล	23015
	Physici		1. Decedent's Name (First, Middle, La May V.	Agnew					2. Date of De Month	Day	Year	3. Time of Death
	/Medi		4ar Facility Name (If not institution, given the Parkette Parkette)	1 11.15.	al Cent	9/ 4b	C 1.	Location of Death	04.0	1 1	y of Death	(0)
	Funeral Director		5. Social Security Number 213–50–6154		(In yrs. last bii		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 5/12/1	th y, Year)	9. Birthpla Count	ace (State or Foreign
74	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Wicom		10c. City, Tow		n				10	ld. Inside City Limits 1 □Yes 2 🛛 No
783	3a or 28	al Dire	10e. Street and Number 20510 Nanticoke	e Dr.		1	Of. Zip Code 2184()		10g. Citizen of USA	What Count	ry?
900-30-	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Wher than "natural", or items 23a or 28a-f show out, the Medical Exarching must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Decedent of H s, specify Cuba es 2 X No	ispanic Origin? (Sp un, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Ra Bla Specia	ce - America ick, White, et	
90 CL	22 should be filed within 72 hours 12 should be filed within 72 hours In and Mental Hygiene. 7 Is marked other than "natural", traumatic event, the Medical Eas	Be Completed	15. Decedent's E (Specify only highest gr.	ducation ade completed) College (1-4or 5+	-)	(Give kind life. DO N	s Usual Occup of work done of IOT use retired	ation during most of work d)	ing	16b. Kind of E		
3 5	led will her the	S	10	_		clerk	Т		(=: . A.C. (.)		1 Secu	rity
∑ Pur	= 0 %	Be	17. Father's Name (First, Middle, Last Thomas Marr)				18. Mother's Name	<i>(First, Middle,</i> Thomps		ne)	
$\frac{2}{5}$	2 should 1 and Mei 1s marker aumatic	ဥ	19a. Informant's Name/Relationship	(Time Print)	106	Mailing Ac	Idrana (Strant	and Number or Rur	_		State 7in	Cada)
Maryland	nd 2 s lith ar 27 is rtrau		Norma McCready/da		11	•		oke Dr.,				300e)
∫ Ma	s 1 ar of Hea		20a. Method of Disposition				(Name of ry or other plac		Date	20c. Location		vn, State
~ E	Pages nent of int: If it		1 ☐ Burial 2 ∰ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		1		remato:	i i	/08	Salisb	arra. N	MD
Balti	permit, Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic es once.		21. Signature of Funeral Service Lice	-	Sailsk	00 No	man and Addus	on of Facility				ssociation 04
•	Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused to one cause on each line a. Due to (or as a	э.	not enter th						Approximate Interval Between Onset and Death
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rds.	w requires that the de been signed by the should be detached	ed by Pr	Part II. Other significant conditions	ontributing to death but	t not resulting in	n the underl	ying cause give	en in Part I.		obacco use con ⁄es 2 ⊠ No		e cause of death?
Division of Vital Records.	sician; The law re certificate has be irector, page 2 sho		25. Was case referred to medical					26. Place of Deat	1 □ Yes	osy rmed? 2⊠No	Were autop prior to com death? 1 □ Yes 2	sy findings available inpletion of cause of 2 No
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ō	g Phy terthi	i i	27. Manner of Death	28a. Date of Injury (Month, Day,		Time of Injury	28c. Injury Work		28d. Describe		1 77	,
<u>.</u> j	Attending Isr death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	n	rear)	ingury ř		Yes 2□No				
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injur- building, etc.	ry - At home, fa (Specify)	arm, street, f	actory, office		28f. Location (\$ City or Tov	Street and Num. vn, State)	ber or Rural	Route Number,
	ne Hospital n 24 hours a he Funeral I pletely filled	Medical		nysician: To the best of miner: On the basis of each manner state	examination ar							
	To the within 2 To the comple	M	29b. Signature and title of certifier	5 0.			29c. License			29d. Date signe	-	ay, Year)
	Agn)	30. Name and address of pulson who C wis Syder D	completed cause of dea			roll st	r. Sa	Whey	WO 21	.B0)	

State Registrar

31. Date filed (Month, Day, Year)

JUN 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** . 22 M Stewart 06 2008 /Medical 4b. City, Town, or Location of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Days Hours Min. 50 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location death with the Marylan 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. items 23a or 28a-f show Queen Anne's 1 ☑Yes 2 No Director ИD srasonyi 10g. Citizen of What Country? 10e. Street and Number 71 SA Collier 21638 Lane by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret ဥ 19b. Mailing Address (Street and Number of Aural Route Number, City or Town, State, Zip Code) 22 Sherman Way Chester, MD. 2 19a. Informant's Name/Relationship (Type. arner 20b. Place of Disposition (Name of cemetery, crematory or other place) /Date 20a. Method of Disposition 20c. Location - City or Town, State 6/28/08 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Robinson's Cemetery Grasonville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY FUNERAL HOME, P. A.
510 Washington St. Cumbridge, MD. 21613
Approximate 21. Signature of Funeral Service Licensee 23a. Part/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weeks bastrointes TINO /Medical Due to (or as a connequence of): Examiner € 1 as atic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 2 🗷 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 🔀 Natural within 24 hours arter community to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖬 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar GREENE 51

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOUTH

31. Date filed (Month, Day, Year)

CLEMENT

08-05028 Andrea Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ndrea Brown		State of Maryland / Department of Health and Mental Hygiene	1
	Re	For State Gistrar Certificate of Death Reg. No. 2 1 8 2 3 0 1 2 Date of Death 3. Time of Death 3. Time of Death	14
/Physician Nedical Examine		Decedent's Name (First, Middle, Last) Andre (Keith Brown Brown 2. Date of Death Month Day Year 2240 hrs	
negicai Examinei		A Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1
6		Route 322 IAO Oxford Road Easton	1
Funeral	5.	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MWDD/YYYY) Foreign Country Nary I and Country Nar	ıl
Director	1	16-70-7128 1VM 2 F 49 Yrs. Months Days Hours Min. NOV. 13, 1958 County Vary 1and	
	u:	sual Residence of Decedent	1
/ am	10	Da. State 10b. County 10c. City, Town or Location	
aryland aryland at once.	iL	MD Talbot trappe 1 LYYes 2 No De. Street and Number 10g. Citizen of What Country?	1
he Maryland nor 28a-f sh	10	01/47	
death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Was Decodent Ever in U.S. 11.3 Was Decodent of Hispanic Origin? (Specify Yes or No-	7
or items 23	1	Never Married 2 V Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	
ter de		3 Widowed 4 Divorced If Yes, Give Year 1982-1985 1 Yes 2 No specify: Specify: Specify: Specify:	_
urs afturaf" turaf" amine		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind or work durie december) 16b. Not use retired)	1
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5-0036 6-0036 1ygiene. other than "natural" the Medical Examine	L	Elementary/Secondary (0-12) College (1-4 or 5+) Po Stal Automaticn Spec. Printing 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	+
Hygi d oth	3 1	7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malder Surname) 18. Mother's Name (First, Middle, Malder Surname)	1
21215-0036 ould be filed within 7 d Mental Hygiene. Is marked other than the cevent, the Medica		John Howard Brown 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)	\Box
~ 5 5 5 T	-1.	Angela Brown 29083 Sanderstown Road Trappe, MD, 21675	싀
	2	20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	-
Ses t of H		Weburial 2 Cremation 3 Removal from State Paradise Connetery 7/5/08 Trappe, MD.	
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/Medical raminer		Immediate Cause (Final disease a Multiple Injuries	┪
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		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
		cause. Enter Underlying Cause (Disease or Injury that initiated Due to (or as a consequence of):	╣
ted msit	Ž	events resulting in death) Last	4
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60, ate be hysici e buri		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year	
68760 certificate nding phy	au/a	3b. Was decedent pregnant in the past 12 months? Fetal death 3 Ectopic pregnancy Month Day real	
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c law e has	Completed	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
I Re tifical or, pa		25. Was case referred to medical 26.Place of Death (Check only one)	-,
/ita ysicia his cer direct	e Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other: Scene	8
of Nag Ph.	⊢t	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Describe now injury occurred	
Sion Attendia death. cctor: A	aţio	Pending Jun 29, 2008 2156 hrs	itv
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the restiter death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be deached in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be or Town, State)	_
Spital hours aneral rilled	င်	4 Homicide determined (Specify) Major Road / Highway Route 322 IAO Oxford Road, Eastorit, MiD 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
		one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To t with To t	Medical	and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)	
	-	O.C.M.E. June 30, 2008	
LI	-	30. Name and address of person who complete leath (Item 23a)	
101	ĺ	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	_
Sta	ate	31. Date filed (Month 1947) 1947 2008 32 egistrar's Signatury	
Regist			_

ORIGINAL

		For State	State	of Marylan		artment of H	ealth and M Death		en 2 008	23048
		Registrar 1. Decedent's Name (First, Middle	e, Last)					2. Date of Death		3. Time of Death
Physicia		Joan Bland						June 29.	Day Yea 2008	9:43 A.M
/Medic Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, or	Location of Death		4c. County of De	
		St. Vincent Ca	are Cente			Emmits			Freder	
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs.		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
Director	}	579-66-8098 Usual Residence of Decedent			90 Yrs.			June 30,	1917 Co	olorado
land ow	1	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
Mary -fah	ţ	MD Fred	erick]	Emmitsl	ourg				1 ☑ Yes 2 ☐ No
r 28s	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What	Country?
h witi		335 South Seto	n Avenue			2172	7		U.S.A.	
72 hours after death with the Maryland natural; or Itama 23e or 28e-f show scal Examiner must be notified at	Funeral	11. Marital Status		cedent Ever in U Forces?	I.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Bfack, W	nerican Indian, nite, etc.
or Its	y Fu	1 ☑ Never Married 2 ☐ Mar	ried 1 ☐ Yes	2 ⊠ No Sive		1 ☐ Yes 2 ☑ No	Specify:		Specify:	
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ild be lental ked c	To Be	John Bland					Willow	Clare He	ckart	
d 2 should be filed with the and Mental Hygiene. 7 Is marked other the traumatic avent, the traumatic avent.	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address (Street	and Number or Rura			, Zip Code)
5 = 2 z		Sister Camilla	Harant/I	POA	333	South So	eton Aven			
permit. Pages 1 and Depermit. Pages 1 and Depertment of Health Important: If itam 27 any Injury or other tronce.		20a. Method of Disposition 1 Burial 2 Cremation	2 Demoval fro	20b. F	Place of Dispo cemetery, cre	sition (Name of matory or other place JNIVersi		Date 2	Oc. Location - City	or Town, State
Pages ment of ant: If its ury or o		4 Donation 5 Other (5		Med	dical	School	// 1/		ashingto	<u> </u>
Depermit. Depertments Imports any Injury.		21. Signature of Funeral Service	Licensee		1				-	ineral Home
3 40 5 8 9		The	100							,DC 20011
		23a. Part1. Enter the disease, o shock, o heart failure. List	r complications that t only one cause or	t caused the deal each line.	th. Do not en	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate fnterval Between Onset and Death
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/Medical Examiner		resulting in death)	Due t	o (or as a consec	quence of):	ナン	-7	- ,	200.0	1
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led nsit	nine	cause. Enter Underlying Cause (Disease or injury	& <i>D</i> .	. 0	101000,	0 200	cala	1 1.	0000	57M
ate be executed shysicien end the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due t	o (or as a consec	quence of):	Val		or or	3 Dan	
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ificate as the	edic		0 -01	71	1					
The law requires that the death certific the law requires that the death certific ate has been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn		∃Ectopic pregnancy	,		23d. Date of	
death of for	icia	in the past 12 months? 1 □ Yes 2 No		gnant at time of		Other (specify)			Month	Day Year
by th	hys	9 □ Unknown [®]								
gned ganed	by	Part II. Other significant conditi	ions contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.		4.4	to the cause of death?
equir equir ould	ted							1 🗆 Ye	s 340 00 3L	Probably 4 Unknown
lawr as be	pie							24a. Was ar autops	y prior	autopsy findings available to completion of cause of
The The sate h page	Completed							perform 1 Yes 2	ed? death	? ′es 2□ No
To the Hospitel or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	Be	25. Was case referred to medica examiner?				0		h (Check only one		
this of all dire	2	1 ☐ Yes 2 No		☐ Inpatient 2 ☐ te of Injury	ER/Outpatie		Nursing Ho	ome 5 Reside	nce 6 Other (5	pecify)
ling F After funer	on	27. Manner of Death 1 Natural 5 ☐ Pendi	ing (M	onth, Day Year)	Injury	Wor	k? Yes 2□No	200. Describe no	w injury occurred	
death death / the	cat	3 Suicide 6 Could		nce of Injury - At h	nome farm st	reet, factory, office	100 20.10	28f. Location (Sti	reet and Number of	Rural Route Number,
Oracle of A	Certification:	4 ☐ Homicide determ	mined 200. Fia	ilding, etc. (Speci	ify)	reot, reotory, omeo		City or Town		
spital ours neral filled		29a. Certifier 1 Certifyi	ing Physician: To I	the best of my kn	lowledge, dea	th occurred at the tir	me, date and place,	and due to the ca	use(s) and manne	as stated.
24 h	edicai	(Check only 2 Medica one)	I Examiner: On the and ma	basis of examin anner stated.	ation and/or in	ivestigation, in my o	pinion, death occur	red at the time, da	ate and place, and	due to the cause(s)
To th	Me	29b. Signature and title of certific	er) -	29c. Licens	se number	25	d. Date signed (M	onth, Day, Year)
		Bouter	Krow	Pel-K	Till	PO HOO	54403	> 17	ane ?	30 2008
		30. Name and address of persor	n who completed ca	ruse of death (Ite	m 23a) (Туре	Print) 12	1-123	Teens?	Main	Toent
		Donital K	RELUPE	L-fork,	ICK	V.O.E	men T.	strains,	mp.	21727
Sta		31. Date filed (Month, Day, Year		Registrar's Sign	nature	. 16	į	Ų.		,
Regist	rar	JUL 02	2008	Bur L	7 AM	MIL				

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** June 28, 2008 9:10 PM Sylvia Levine Beram /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🔀 F Months Days May 16, 90 1918 New York Director 579-14-1626 Usual Residence of Decedent if and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It has a reason as a reason and a show then 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It we Medical Examinat must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a State 1 XYes 2 ☐ No Funeral Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6111 Montrose Road #910 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Rosenberg P Philip Levine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr. once. Philip C. Beram - Son 16900 Vine Court Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State King David Mem. Gdns. 7/1/2008 Falls Church, Virginia 4 Donation 5 Dother (Specify) of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels, 1170 Rockville Pike Rockville, MD 2 Rockville, MD 20852 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** Bradyarrhythmia /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, a year and a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for esca consequence offs law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Physician/Medical the cate has been signed by the attending p page 2 should be detached for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The this certificate 2 No Vital 1 🗆 Yes 1 ☐ Yes 2 🗆 No Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 ₩ Natural 5 Pending investigation nours after death, neral Director: Aft y filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D066896 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road Bethesda, MD 20814 Matthew Leonard, MD 31. Date filed (Month, Day, Year) egistrar's Signature 2008 Registrar

DEFAM

08-05167

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

William Joseph Bu	1	- For State	St	ate of Mar	yland /	•	ment of <i>icate of</i>	Health and Death	Ment	al Hyg		Reg. No.	20	0 8	230	15
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Medical Examine		WILLIAM 4a. Facility Name (i				II		4b. City, Town, or L	anation of	f Dooth	July 5, 20	008	County of	Death	1255 hrs	
•	ľ	21973 Kelle		. 5	(Humber)			Rock Hall	Location of	Death			ent	Deall		
Funeral	-	5. Social Security N	lumber	6. Sex	7. Age	(In yrs. last l	birthday)	If Under 1 Year	If Under		8. Date of B	irth(MM/D		9. Birthpl Foreign	ace (State or	
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the M riffied Direct		21973 K	ELLEY	PARK DR	•			21661				1	USA			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If it file 27 is marked other than "natural", or items 33a or 28a-f show injury or other traumatic event, the Medical Extensive must be notified at once. To Be Completed by Funeral Director	5	11. Marital Status 1 X Never Marrie	od 2 🗆 M		Decedent E d Forces?	ver in U.S.		as Decedent of Hisp es, specify Cuban,				0-	14. Race - White,		n Indian, Black,	
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Box 6876C the death certificate the attending phys hed for use as the browsician/Me	2	IF FEMALE: 3b. Was decedent		23c. If y		e of pregnar	ncy	etal death 3		c pregnan		230	I. Date of one of the country of the	delivery Da	y Year	
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		30. Name and addr Patricia Aro	nica-Polla	k MD. Ass	istant M	edical Ex	aminer	111 Penn St	reet, Ba	altimore	e, MD 212	01				
State Registra	e	31. Date filed (Mon	th, Day Year	4 2008	Registrar'	s Signature	KA	hack .								
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DHMH 17 Rev 1/2001 OCME 2006

		Registrar		Cei	rtificate of Dea		Heg	, No.	
·		1. Decedent's Name (First, Middle,	Last)			2	Date of Death Month	Day Year	3. Time of Death
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Ne N 8s-f	ct	MD Wicon	nico	Salisbury					
or 2	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	ntry?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Physician P. M arver 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sivui Hospital Baltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Morth, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months M 2□ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director Balti more 1XYes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 5 "natural", or items 23a Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Im Mag ponce. Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. College (1-4or 5+) Mone. none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sina Hospita Balto. mD,21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ☐ O Sp. TAL HOSPITAL 22. Name and Address of Facility 5, NA 21. Signature of Funeral Service Licensee D 15 D 05 A L HOSPITALOS 2401 W Belveoree Ave Baltimore MD usa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** xtreme disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any conditions, if any conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dita to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be execut and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner 7 1 ☐ Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DCA After this Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 □Yes 2 □No within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 000-RES

Registrar

Sinai Hospital 2401 W. Belvedere Ave Balto, mp, 21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ,2008 12529PM Tune John Christie 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year) Months Days Hours Min. 1 M 2 □ F 577-46-6134 76 29, 1932 Florida Feb. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 14 Yes 2 □ No Prince George's Maryland Bowie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14001 Pleasant View Drive 20720 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. ² No 1951-1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Specify: Black 1 □Yes 2X No Specify: 3 Widowed 4 Divorced 1972 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sgt. First Class U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daniel Christie Nancy Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14001 Pleasant View Drive Bowie, MD 20720 Anna H. Christie/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/2/2008 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ue to (or consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1xx Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

and

ф

certificate

this funeral

After

within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician:

Hospital or Attending

death.

Physician

Examiner

Funeral

Director

show

Director

Funeral

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exp., it at must be muffled and 2008.

Maryland 21215-0036

Baltimore,

/Medical

burial-transit attending physician for use as the buria icate has been si director,

The law requires that the death certificate be executed

Records, P.O. Box 68760

Division of Vital

Exami Physician/Medical Completed Be မ

Certification:

Medical

29a. Certifier

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartifie

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of seath (Item 23a) (Type, Print) 8118 021a

Good Lock Road Lanham MD 2070

State Registrar 31. Date filed (Month, Day, JUL 0 1

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 23054 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Edward Cline July 9, 12:32 P M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6186 Trotters Glen Drive Hughesville Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral ™** M 2□ F Days Hours Director 147-24-5018 76 24, 1932 Jan. New Jersey Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hygiene. and the filem 27 is marked other than "natural", or Items 23a or 28a-f show ant; if item 27 is marked other than "natural", or Items 23a or 28a-f show unty or other traumatic event, the Meckel Examiner must be notified at uny or other traumatic event, the Meckel Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Marion Florida 0cala 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 66 S.E. 63rd Terrace 34472 US Completed by Funeral Α 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Petty Officer U.S. Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cline 0scar Gertrude Miller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Cline/Spouse 66 S.E 63rd Terrace, Ocala, FL 34472 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o once. 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Brinsfield-Echols 7/10/2008 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A - M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ces **Physician** disease or condition resulting in death) Nee /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mjury that initiated events Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence SCOther (Specify) Residence Hospital: 1 ☐ Yes %☐ Pro Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Hospital or Attende within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🛨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 0 2008 Registrar

			1 - State Registrar	Cei	rtificate of I	Death		Reg. N.20)8 23055
de.	Physici /Medi		1. Decedent's Name (First, Middle, Last) Abert Andrec	wC	1 resu	se//	2. Date of De- Month	Day 20	3. Time of Death 908 11:35a M
	Examir	er	4a. Facility Name (If not institution, give street and number) 209 Melbourne Blvd.			Location of Death	,	4c. County	of Death Cecil
经上	Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. In 1. 2	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da March 2	th y, Year) 2, 1918	9. Birthplace (State or Foreign Country) Maryland
	e Maryland ta-f show tified at	ctor	Usual Residence of Decedent 10a. State	, Town or Lo		kton			10d. Inside City Limits 1 □Yes 2X No
	th with the 23a or 28 ust be no	ral Director	10e. Street and Number 209 Melbourne Blvd.		10f. Zip Code	921		10g. Citizen of W	vhat Country?
5-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Arked other than "natural", or items 23a or 28a-f show afte event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2🖾 No	ispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No Rican, etc.)		e - American Indian, k, White, etc. : White
21215-0	vithin 72 h ne. han "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life.		during most of working ()	ng		rat Farms
7	ifiled v I Hygie other t ent, th	Be Co	Eight Years 17. Father's Name (First, Middle, Last)		Gardener	18. Mother's Name	(First, Middle,		posit, Maryland
Maryland	ould be Menta arked atic ev	To B	John Edward Creswell			I	Maude V	. Whitel	Lock
Mar	d 2 should th and Men 7 is marke traumatic	1	19a. Informant's Name/Relationship (Type. Print) Mary Louise Burlin			and Number or Rural		-	State, Zip Code) ryland 21904
altimore, l	Pages 1 and 2 should be nent of Heath and Mental int: If item 27 is marked o iny or other traumatic eve		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ace of Dispo emetery, crer	osition (Name of matory or other place). 1 Cemeter	e) Da	ate	20c. Location - 0	City or Town, State
Balt	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service License	M. Pe	erryville	terson & S . Marvland	1 2190	3-0766	ne, P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	Do not ent	er the mode of dyin	g, such as cardiac or	r respirato ry ar	rrest,	Approximate Interval Between Onset and Death 2 weeks
68/60,	be executed sician and burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to or as a consequence of consequence of the consequence of						
.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attendeath. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery nth Day Year
ras, r	quires that in signed b uld be deta	۵	Part II. Other significant conditions contributing to death but not result	ting in the ur	nderlying cause give	en in Part I.	23e. Did to	N	ibute to the cause of death? 3 ☐ Probably 4 ☐Unknown
Hec H	cate has bee	Completed					24a. Was a autop perfor	rmed? pi	Vere autopsy findings available vior to completion of cause of eath?
VII	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 No Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Othe	26. Place of Death			(0 (1)
ion or	ending Phy ath. or: After this ne funeral d	ation: To	This make the second se	28b. Time of Injury	28c. Injury Work	4 - Indising fion		dence 6 Othe	
DIVISION	I o the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At hom building, etc. (Specify))			City or Tow	vn, State)	er or Rural Route Number,
	e Hosp 24 hou e Fune etely fi	Medical	29a. Certifier (Check only one) (Check o	ledge, death on and/or in	n occurred at the tim vestigation, in my op	ne, date and place, a pinion, death occurre	nd due to the ed at the time,	cause(s) and mar date and place, a	nner as stated. and due to the cause(s)
	Nithin To the Compl	Me	29b. Signature and title of certifier Flower Shule A		29c. License	number 4 20 50		29d. Date signed	(Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 2) Prashant Shukb, mo 15 S. Pau	23a) (Type, I			mo	21001	
÷.	Sta Registra	te ar	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ire does	٧				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ^{Day}2008 Helen Louise Cohn 4:20 A M June 24, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Fox Chase Rehab Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/27/1928 9. Birthplace (State or Foreign **Funeral** 579-30-4435 1 □ M 2 🛣 F Months Days Hours Washington, DC Director 79 Usual Residence of Decedent 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show idical Examiner must be notified at 10d. Inside City Limits MD Montgomery Silver Spring 1 TYes 2 No 10e. Street and Number 10f. Zip Code 20910 10g. Citizen of What Country? 8512 Milford Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 21 No Specify Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FEMA 2 Correspondent ges 1 and 2 should be filed voit of Health and Mental Hygie If item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sophie Goldman Harry Cohn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Zucker / Sister 8510 Milford Ave. Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) 07/03/2008 | Frederick, MD Mt. Olivet Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. ank of Sous 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Coronary Syndrome Instant /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aortic Aneurysm 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Pneumonia 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed' certificate 1 ☐ Yes 2 ☐ No 2**X** No Physician: director, 25. Was case referred to medical 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending (Month, Day Year) Injury 1 Natural 5 Pending death. 1 ∏Yes 2 ∏No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fund completely f one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) D28656 July 1, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi MD 15225 Shady Grove Rd. #208 Rockville, MD 20850 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death John Frederick Chamberlain, Sr. Month Day 28 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wicomic ake Salisbur at Social Security Number Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Days 216-24-2077 79 2/1/1929 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Worcester Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2150 St. Lukes Rd. 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 X Yes 2 □ No Army/ If Yes, Give Year or Dates: Navy 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 general manager General Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Henry Chamberlain Matilda E. Litzau 19a. Informant's Name/Relationship (Type. Print) Stephen A. Chamberlain/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2150 St. Lukes Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Wicomico Memorial 1 Surial 2 □ Cremation 3 □ Removal from State 7/3/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Park 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP Tarre 23a. Part1. Enter the disease, or complications that cau of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death yeath Immediate Cause (Final disease or condition resulting in death) arterioscler Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy ormed? 2**⊠**No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital:

Physician /Medical **Examiner**

be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

Funeral

Director

f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at

altimore, Maryland 21215-0036

Examine Physician/Medical <u>۾</u>

burial-transi attending physician and for use as the burial-trar ed by the detached Completed page 2 s Be

certificate

After this funeral

Hospital or Attending Physician:

death.

within 24 hours after death To the Funeral Director: ompletely filled in by the in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

5 Pending investigation

1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

3□ DOA 28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D29505 29d. Date signed (Month, Day, Year) 06-28-08

80. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 GREGORIO 31. Date filed (Month, Day, Year)

State Registrar

Certification: To

Medical

JUL 02

6 Could not be determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 2008 2045 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Year) Apr 21 1934 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√□ F Days Hours 215-32-5161 74 Yrs. Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinate must be notified at Director Maryland Anne Arundel 1 ☐ Yes 2 No Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4087 Old Muddy Creek Rd. 21037 USA Funeral and 2 should be filed within 72 hours after death v lealth and Mental Hygiene. m 27 is marked other than "natural", or items 23. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 \$ 1 ☐ Yes 2√∑ No Specify Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Geriatric Assistant Dr. Emily Wilson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Davis Annie Clargett ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 permit. Pages 1 and 2 s Department of Health a important: If item 27 is any injury or other trau once. 12507 Woodstock Dr. East Upper Mariboro, Francine B. Easton(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chews U.M. Church 7-1-08 West Piver, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 What and Address of Facility Sons Mortuary, 821 West St. Annapolis, Mo. arry MO088 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Muccardial Jarcho /Medical Due Due as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown signed by the contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) 2100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3**2**00A 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Naturat death. ineral Director: A 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26/08 50756

State Registrar 30. Name and address of person who come

JUL 0 1 2008

31. Date filed (Month, Day, Year)

Dr.J

Annapolis Md

eted cause of death (Item 23a) (Type, Print)

Ho

			For	State of Marylan				Mental Hygi	iene	
			1 - State RegistrarAmend #26 Pe		72/ 08e r	tificate of	Death		g. No2 () ()	8 23059
	Physici /Medic		Decedent's Name (First, Middle, Last, John	M	Do	uglas	Sr.	2. Date of Death	Day 200	3. Time of Death 12:00p ^M
	Examin		4a. Facility Name (If not institution, give				r Location of Deat	h	4c. County of	Death
			3166 Guilford D		In a 4 1 1 4 4 4 1	Wald		100 (5:4)	Char	
	Funeral Director			7. Age (In yrs.)	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 11/2/	Year) 1965 M	Birthplace (State or Foreign Country) aryland
	A A		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
To Charles	the marylar 289-f show	tor	Maryland Charle			L Alton				1 X Yes 2 □ No
Ť,	or 28	Jire	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	at Country?
4	236 3236	rait	8610 Fair Groun				611		USA	
21215-0036 duithin 72 hours after death with the Mandand	is rain a should be new winn it a hous after beath with the maryal of Health and Mental Hygiene. If then 27 is marked other than "natural", or Itams 23e or 28e-f show than traumatic avent, the Medical Examinational be notified at	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cub ☐ Yes 2X No		Specify Yes or No- to Rican, etc.)	Black,	American Indian, White, etc. Black
5-0	natur	eted	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	ent's Usual Occup	nation	rkina	16b. Kind of Busir	ness/Industry
2	han *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		no NOT use retire. hanic	during most of wo d)		oranduw	ine Auto
CA Z	Hygie thar t		12 17. Father's Name (First, Middle, Last)		Mec	nanic	18. Mother's Na	me (First, Middle, M	_	The Auco
	and Mental Hygiene. is marked other than aumatic avent, the Me	To Be	John		ougla		Claudi	.a	W	ills
Mar	and 2 sind ealth and n 27 is m		19a. Informant's Name/Relationship (Ty Claudia Douglas							^{ate, Zip Code)} 20613 Maryland
ore,	of Health fitam 27 r other tra		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of natory or other place			20c. Location - Cit	
imc	ment of and: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	t. Pe	ters	7/8			,Maryland
Baltimore,	perim. Fages I and Department of Health Important: If itam 27 any injury or other tr once.		21. Signature of June al Gervice Licens		91 20	Name and Addre	ess of Facility Actions Rose	dams Fun d. Aquas	eral Ho	ome PA yland 20608
			23a Part1. Enter the disease, or compete shock, or heart failure. List only or	cations that caused the death	n. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death)	Paurc	est	20	Con	cer.		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					
		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
a di contra	sician and burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a consequ	nence of):					
Box 68760,	sician e buria	dicai E		1	doi100 01).					
.89	ng physi as the b	Medi	is service							
Box	attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Fetal	Ideath 3	Ectopic pregnancy	/		23d. Date of	
0 8	y the a	Physician/Me	1 Yes 2 No 9 Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (specify) _			la contra	Jay 15a
S, P	igned by the s	by Pr	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the un	dothing source on		230 Did tob	acco use contribu	ite to the cause of death?
ord		=				iderlying cause giv	en in Part I.	236. Did 100		-
S >	pino	te					en in Part I.			Probably 4 Tinknown
è è	has been si	npletec				denying cause giv	en in Part I.	1 ☐ Ye 24a. Was ar autopsy	s 2 No 3(Probably 4 Inknown re autopsy findings available of to completion of cause of
al Records, P.O		Completed				derlying cause giv		1 Ye 24a. Was ar autopsy perform 1 Yes 2	24b. We prio dea	Probably 4 Inknown re autopsy findings available or to completion of cause of
Vita		Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2		Oth	26. Place of De	1 Ye 24a. Was ar autopsy perform 1 Yes 2	24b. Wei	Probably 4 Pinknown re autopsy findings available r to completion of cause of th? Yes 2 No
of Vital	this certificaral director, p	To Be	examiner? 1 Yes 2 No F	Hospital: 1 □ Inpatient 2 □ 28a. Date of Injury (Month, Day Year)	ER/Outpatient	Oth	26. Place of Dei er: 4 ☐ Nursing H	1 Ye 24a. Was ar autopsy perform 1 Yes 2	s 2 No 3(24b. We prio dea (100 1 December 1 Decembe	Probably 4 Nhknown re autopsy findings available r to completion of cause of th? Yes 2 No
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 3. Time of Death 2:20 1. Decedent's Name (First, Middle, Last) **Physician** РМ Vera Marie Dilworth July 2008 8, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 18926 Russell Road St. Mary's Valley Lee If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 K F 71 220-34-8930 June 11,1937 Director Maryland Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland St. Mary's Valley Lee 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or idical Examiner must be 18926 Russell Road 20692 USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2K Married 1 ☐ Yes 2 🛣 No Specify. Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fil f Health and Mental H tem 27 is marked oth Be Albert Edward Vernon Saunders, Sr. Elizabeth Viola Redman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 18926 Russell Road Raymond George Dilworth / Husband Valley Lee, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State July 11. St. George Cemetery 4 Donation 5 Other (Specify) Valley Lee, Maryland วกก์ผ 21. Signature of Fugeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause (Final disease or condition resulting in death) Brain **Physician** 100 lastoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner that the death certificate be executed and I-tran Due to (or as a consequence of) burialphysician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ρ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 No page certificate 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA P this After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending hin 24 hours after death. 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

W

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division or Vital Records,

DHMH 17 Rev 1/2001

Registrar

Karen Bauer,

31. Date filed (Month, Day, Year)

JUL 1 0 2008

M.D.

Mechanicsville, MD 20659

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28103 Three Notch Road

32. Registrar's Signature

			For State Registrar		State of Ma	aryland		artment <i>rtificate</i>			d Ment		giene Reg. No. 2	2008	3 2306	1
			Decedent's Name	(First, Middle, Las	r)							ate of Dea	ath		3. Time of Death	-
0	Physici /Medio	_	Margar	et Ellen	Hastings	Downe	<u>y</u>					lonth LNe	26_	Year 2008	17:15 P	М
	Examir	ıer	4a. Facility Name (If	0						Location of De		L 1		unty of Deat		
	- 4	4	5. Social Security Nu				enter ast birthday	If Under 1		If Under 24 H	/ -	mal. ate of Birt			m/CO hplace (State or Foreign	an
· Since	Funeral Director		214-46	4.0	M 2 ∏ F	61	Yrs.		Days		Ain. (N	1onth, Daj	y, Year) , 1947	Co	untry) Laware	<i>y</i> (1)
	D		Usual Residence of	Decedent		10.00	-				110	, 10	, 1017	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	arylar show	_		10b. County Wicon	of an		, Town or L 1mar	ocation							10d. Inside City Limit 1 ☑ Yes 2 ☐ N	
	the M	Director	MD 10e. Street and Num			De	ilmai	10f. Zip C	Code				10a. Citizen	of What Co		
	3a or		105 E.	Pine Str	eet				2187	5			U.S.		•	
7	death	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	S. 13.		_	spanic Origin? n, Mexican, Pu	? (Specify Y	es or No-		Race - Ame Black, White		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to fleatin and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 Never Marrie		1 ☐ Yes 2 🔀 I If Yes, Give			1 ☐ Yes 2		Specify:		, 0.0.,		pecify:	white	
215-0036	hours tural' al Ex	ed b		15. Decedent's Edi	Year or Dates:		16a. Dece	dent's Usual	Occupa	ation			16b. Kind	of Business/		
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in a	be file	B	17. Father's Name (18. Mother's I	Name (Firs. a She			rname)		
Maryland	hould d Mer marke matic	၉	19a. Informant's Nai	Hastings	ine Print		10h Maili	na Address /	Stroot	and Number o				own State 3	Zin Cada)	
≥	nd 2 s lith an 27 is i			e Willey	(Siste	r)				Avenu			ar, DF			
J	other	li	20a. Method of Dispo	osition	`	20b. Pl	ace of Disp	osition (Name	e of	i	Date			tion - City or	<u> </u>	
3 <u>E</u>	Page nent c int: If iry or]Cremation 3 ∐I 5	Removal from State)		-	•		ery 6-	29-20	08	Delm	nar, D	elaware	
Baltimore	permit. Pages 1 and 2 should be filed within Department of Headth and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Meone.		21. Signature of Fur	neral Service Licens	see			2. Name and	Addres							
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			shock, or hear	failure. List only o	ne cause A each li	ne.	. Do not en	ter the mode	or dylin	g, such as can	diac or resp	oratory ar	rest,		Approximate Interval Between Onset and Death	
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	Examiner				1	jan	,							1	w on	
	= = = 	iner	Sequentially list con if any, leading to impression cause. Enter Under	ditions, nediate lying	Due to (or as	consequ	ence of):								7	
	ecute and I-trans	Examiner	that initiated events resulting in death) La	ast	c. Due to (or as	a consedii	ence of).									
68760,	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	alE		l	4		0.100 017.									
687	ifficate g physas the	ledical			a											
Вох	th cer tendin r use	an/N	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome 1□Live birth			⊒Ectopic pre	onancy				23d	I. Date of del		
O. E	ne dea the at hed fo	Physician/M	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant at 9□Unknown			Other (spec						Month	Day Year	
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or Vital Records,	quires n sign ald be	d by									_	1 🗆 🗅	res 2⊒	√0 3 □ Pr	robably 4 □Unknov	vn
000	aw requir is been si 2 should	Completed									2	24a. Was		24b. Were au	utopsy findings availab)le
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/ita	Physician; The r this certificate har ral director, page	Be (25. Was case referre		114-1				Lau	26. Place of	Death (Che	eck only o	ne)			
or	Phys this al dii	은	1 Yes 201 N 27. Manner of Death	40	Hospital: 1 ☐ Inpatie		28b. Time of			4 La Nursin			dence 6 D	Other (Spe	cify)	
on	ng ftel	tion	1 Natural 2 Accident	5 Pending investigation	(Month, Da		Injury	_M	lc. Injury Work	? Yes 2∐No	200. L	Describe i	low injury o	ccurred		
Division	Attend r death ector: , by the f	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injuding, et			reet, factory,	office		28f. Lo	ocation (S	Street and N	lumber or Ri	ural Route Number,	===1
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1	long!		30. Name and addre	ss of person who c	ompleted cause of d	eath (Item				1	/		1	-6/-6	(i)	\neg
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	For	of Dooth	2000 20002
Physician /Medical	1. Decedent's Name (First, Middle, Last) Agnes R. Davis	Month	Day Year 1335 M
Examiner Funeral Director	Peninsula Regional Medical Center Sales, Social Security Number 9 6, Sex 7, Age (In yrs. last birthday) If Under 1 M	par If Under 24 Hrs. 8. Date of Birt hys Hours Min. (Month, Da.	
pu »	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Wicomico Salisbury		10d. Inside City Limits 1
fier death with the Maryland fiers 23a or 28a-f show fire and the putfled of Funeral Director			10g. Citizen of What Country? USA
D36	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates:	No Specify:	Specify: white
21215-00 ed within 72 hou ygiene. ter than "natura t, tre Wedlan!	12 College (1-4or 5+) nurses aide	2. Date of Death Day Gaz Salt Gaz Gaz	
Maryland d 2 should be file th and Mental H; ris marked only traumatic event To Be	17. Father's Name (First, Middle, Last) George Collier	Rebecca Allen	
e, Mar I and 2 sh Health and Pm 27 is m ther traum	Larry Davis/son 1602 Mt. F	Mermon Rd., Salisbu	ry, MD 21804
Baltimore permit. Pages 1 a Department of He Important: If iten any Injury or oth once.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	place) al 7/1/08	Salisbury, MD
Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed the death. Since death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit and in by the funeral director, page 2 should be detached for use as the burial-transit and in by the funeral director. The Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertains Cause (Disease or injury that initiated events resulting in death) Last a. Due to (y as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.	lial infen	
P.O. Box 68 nat the death certific d by the attending p etached for use as: Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic preg 4 □ Pregnant at time of death 5 □ Other (specif		,
Records, P he law requires that e has been signed b ge 2 should be dete mpleted by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying caus	girairiir	1/
siclan: The law requires to entificate has been sirector, page 2 should		autor perfo 1 □ Yes	psy prior to completion of cause of death? 2 ★ No 1 □ Yes 2 □ No
Physiclan this certifi al director	25. Was case referred to medical examiner? 1 Yes 2 No	Other:	
tal or Attending Phy is after death. al Director: After thised in by the funeral of	27. Manner of Death 1 X Natural 2	1 ☐ Yes 2 ☐ No lice 28f. Location (Street and Number or Rural Route Number,
Division To the Hospital or Attentivithin 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurred at the time,	date and place, and due to the cause(s)
To the within common	29c. Li	9 2 1 6 7 Ly	29d. Date signed (Month, Day, Year) 6 (30/48
State	30. Nane and address of person who completed cause of death (Item 23a) (Type, Print) A Cocces wo 1346 31. Date filed (Month, Day, Year) 32 Registrar's Signature	~ 12, Lab.	nay Md 2184/

JA Cockes, NO
31. Date filed (Month, Day, Year) State JUN 3 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 Marv Elizabeth Emond June 28, 8:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 14780 Banks O'Dee Road Newburg Charles 7. Age (In yrs. I 8. Date of Birth Sept. Day 8 earl 934 5. Social Security Number 219-30-2531 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) WVA last birthday **Funeral** 1 □ M 2 🕅 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 ☑ No Charles Newburg Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14780 Banks O'Dee Rd. 20664 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Drivers Examiner 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise P. Martin Kenneth Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth Ford/Son 1450 Gilbert Rd. Arnold, Md. 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 7/1/2008 Charlotte Hall, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. MO0945 211 St. Mary's Ave. La Plata, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Emphyseme Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) attending physician Division or Vital Records, P.O. Box 68760 by Physician/Medical page 2 should be detached for use as the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 🏋 No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed?
1☐ Yes 2♠ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 ☐ Yes 2 ☑ No 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Harring, M.D. 102 Centennial Street, Suite 102, La Plata, MD

State

JUL 02 Registrar

32. Registrar's Signature 2008

20646

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23064 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 5:47 AM^N July. 2008 William Everett Ewing, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil 409 Champlain Road North East 8. Date of Birth (Month, Day, Year) Feb. 19,1936 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 XM 2 ☐ F Maryland 218-32-6389 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Cecil North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21901 409 Champlain Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 200 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Concrete Finisher Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Miller Sherman Ewing မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a
Important: If Item 27 is
any injury or other trau
once. 21 Goosemar Ext. Road, North East, Maryland 21901 William Ewing, Jr. / Son 20b. Place of Disposition (Name of cemetery crematory or other place)
North East Methodist Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 7,2008 North East, Maryland 4 □ Donation □ Other (Specify) 21. Signature of Fundal Service 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 2190 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician inknown Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? res 2√ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 after death. 24 hours a within 24

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

4 Homicide

D00060756

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Main St. Slider, MD oksau

State Registrar

Medical

h, Day, Year) 2008

Patricia D. Eckard

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	State of Maryland / Department of Health and Mental Hygiene
	Otate of Mar Maria / Departitelli of Fleatili and Merita Francisc

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			1- For State Registrar		Cer	tificate of	Death		Reg	. No.		2000
	Physicia	an/	1. Decedent's Name (First, Midd	fle,Last)				2.	Date of Death	Day Year		ime of Death
M٠	^{⊿:} cal Exami	ner	Patricia	Dianne	Eckar				July 12, 200	08		813 hrs
			4a. Facility Name (if not institution 9220 Appleford Circles)	_	umber)	4	b. City, Town, or Loca Owings Mills	ation of Death		4c. County of Baltimore		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ist birthday)		f Under 24Hrs. Hours Min.	8. Date of Birth	(MM/DD/YYYY)	9. Birthpla Country	ce (State or Foreign
	Director		437-47-6098	1 M 2 XF	32	Yrs.	Months Days	Hours Mill.	Dec. 7	, 1975	Flor	i da
	<u> </u>		Usual Residence of Decedent 10a. State 10b. County		Inc. City	Town or Location					100	. Inside City Limits
	ow any				Too. ony,	TOWN OF LOCALIN						Yes 2 No
7=	yland a-f sh t once	ctor	Maryland Car	roll			Hampste	ad	100	. Citizen of Wha		
9	e May or 28	Director	4290 Hunt	aman Trai	1		21074		105		.S.A.	
1	with the is 23a		11. Marital Status		cedent Ever in U.	S. 13. Was	Decedent of Hispani		ify Yes or No-			ndian, Black,
1	death r item	Funeral	1 Never Married 2 X M	Married Armed I	Forces?	If Ye	s, specify Cuban, Me	exican, Puerto Ri	can, etc.)	White,	etc.	
7 44	after al", o	by F		vorced If Yes, Give Ye or Dates:	эаг	10,000	Yes 2 X No sp			Specify:	White	
	hours		15. Decedent's Education (Spe				s Usual Occupation (st of working life. DO			16b. Kind of Bus	iness/Indus	try
	36 iin 72 han than dical	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)	contra	ct admini	ctrator		gov't.	cont	racts
	d with	E O	17. Father's Name (First, Middle	e, Last)		COILLIE		Mother's Name (F	irst, Middle, Ma		COILC	acts
	215 be file atal Hy ked o	Be (Robert L. F					Yoland	da Marc	ey		
	MD 21215-0036 to 2 should be filed within 7 this and Mental Hygiene. m 27 is marked other than aumatic event, the 3th dica	2	19a. Informant's Name/Relations				Address (Street an					
	MC stand 2 stand man		John Eckard/ h	usband	T		Huntsman					
-	imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Midical Examiner must be pocified at once.		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal i		Place of Disposi rematory or oth	tion (Name of cemete er place)	ery, L	Date	20c. Location -	City or Tow	n, State
ye. 10, 1	Page ment ment tant:		4 Donation 5 Other S	pecify:		County	Crematio	n 7/15/	/2008	Sykesv	ille,	MD
	Baltimore, MD 21215-0036 permit: Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Juneral Service	Licensee	la tolon	/	ame and Address of F	нагі	zler F	uneral	Home_	
	Physician	-	23a. Part I. Enter the disease, or	r complications that	caused the death.		O Church e mode of dving, sud			sor, MD		oproximate Interval
	'Medical		failure. List only one cause	on each line.			,,		, , , , , , , , , , , , , , , , , , , ,	, ,		etween Onset and Death
1	_xaminer		Immediate Cause (Final disease or condition resulting in death)		myocardi a consequence of						-	
		.	Sequentially list conditions,	b								
		Examiner	if any, leading to immediate cause. Enter Underlying Cause		a consequence of):						
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	D, be ex sician	edical	X UNPENDED				3001 //24/	00 11				
	8760, ificate be	[]	IF FEMALE: 23b. Was decedent pregnant in the		outcome of pregr		al death 3 E	Ectopic pregnanc	v	23d. Date of o	delivery Day	Year
	Box 68 e death certil the attending ed for use as	icia	past 12 months?	4 Preg	nant at time of dea	ath	er (Specify)		,		,	
	Bo ne dear the at	Physicia	1 Yes 2 No 9 V Un	9 Uliki					Too Silvin	<u> </u>		
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	by P	Part II. Other significant condit	tions contributing	to death but not re	sulting in the u	iderlying cause given	n in Part I.		acco use contrib		ause of death?
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	Division of Vital Rec Hospital or Attending Physician: The I 24 hours after death Funeral Director: After this certificate I rely filled in by the funeral director, page	Be	25. Was case referred to medica examiner?	d Inspital:	Inpatient 2	ER/Outpatient	-046	Death (Check onle er Nursing I		esidence 6	Othor: Co.	
	of V Phys ter thi	의	1 Yes 2 No 27. Manner of Death	28a. Date	e of Injury	28b. Time of In			the same of	w injury occurre	_	ane .
	arth rr: Af	틶	1 X Natural 5 Pend	(Mont	h, Day,Year)		1 Yes	2 No				
	r Atte r Atte ter dez irrecto n by tl	licat		stigation 28e. Pla	ce of Injury - At ho	me, farm, stree	, factory, office buildi	ing, etc. 28			r or Rural R	oute Number, City
	oital o	Certification:		rmined (Specify)				or Town, Sta	ite)		
	24 ho 24 ho Func etely f	alc					ed at the time, date a					
	Divis To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Medical	- 6.5	and manner	of examination an stated.	id/or investigati	on, in my opinion, dea					
		Σ	29b. Signature and title of certifie	er do	00-		29c. License nu			29d. Date signe		Day, Year)
•			Carol	- Htll	yew		O.C.M.E	= .		July 13, 200	JQ	
	0	ſ	 Name and address of person Carol Allan, MD As 	who completed cau sistant Medical			treet, Baltimore,	MD 21201				
	C+	ate	31. Date filed (Month, Day, Year)	32 8	egistrar's Signat		M. A	, 21201				
	Regist	_	JUL 1 7	2008	egistrar's Signat	No.		11		2.5		
-	IMH 17 Pey 1/20			OCME								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month D G **Physician** SANDRA 0241 M 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Edgewater
If Under 1 Year | If Under 24 Hrs. 1316 Shore Drive Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 🕽 F Months Days Hours Min. 1/12/1943 **Director** 113-34-2256 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Martinal Expensions. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎇 No |Maryland|Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1316 Shore Drive 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White ş 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Paul Dale Wilburn Evelyn Rau 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilber W. Flowers III 1316 Shore Dr. Edgewater, Md. 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Lincoln Cemetery 7/2/2008 Brentwood, Md. 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service License 2973 Solomons Island Road Edgewater, Md. 21037 23 151 t1. Enter the di A ase, or con shock, or heart fa ure. List only it tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of). Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 1 □Yes 2. INo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To hours after death.

neral Director: After this y filled in by the funeral di this Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Pate signed (Month, Day, Year) 29b. Signature and title of dertifie wind completed cause of death (Item 23a) (Type, Print) EFENSE HIGHWAY ANNAPOLIS MDZ1401 30. Name and address of perso 100 M NICHAEL J 441 .LdE Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 1 2008 Registrar

DHMH 17 Rev 1/2001

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 12:45PM **Physician** Helen Bell Frederick JUNE 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1219 Bacon Ridge Road Crownsville Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 579–52–2004 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) Days Min. 1 □ M 2 🕱 F Months Hours 87 1920 South Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modest Examination to confine a Maryland Anne Arundel Crownsville 1 ☐ Yes 2XXVIo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1219 Bacon Ridge Road 21032 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify Black ģ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Willie David Frederick/foster son 1219 Bacon Ridge Road Crownsville, MD 21032 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any Injury or ott 1 ☐ Burial 2XX remation 3 ☐ Removal from State Baltimore Crematory 7/1/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBROVASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2/5 No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 2'**X**No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 s has autopsy performed? this certificate Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation in 24 hours are. ...
the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year)

State Registrar

Neg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

8601 Veterans Hwy 32. Paistrar's Signature

29c. License number

JUNE 27, 2008

204, Millersville, MD21108

		Please Type or Print in Black In State of Maryland / Dep 1- For State Registrar Ce	artment of Health and M	-	
Physici	an	1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of Death Month	Day Year 3. Time of Death 10:30 P M
/Medic	al	Ruth Annie Guy 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 2,	2008 10:30 P M
Examin	er	St. Mary's Hospital	Leonardtown		St. Mary's
Funeral Director		5. Social Security Number 6. Sex 1 M 2 S F 7. Age (In yrs. last birthday 94 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) March 3,	
land ow		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or L	ocation		10d. Inside City Limits
e Mary a-f sh	ctor	Maryland St. Mary's	Callaway		1 ☐ Yes 2 No
with the	Dìre	10e. Street and Number 20283 Piney Point Road	10f. Zip Code 20620	100	g. Citizen of What Country? USA
death ms 23 r musi	nera		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	Armed Forces? 1 ☐ Never Married 2 ☐ Married If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2XI No Specify:	Rican, etc.)	Black, White, etc. Specify: White
"natur	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	6b. Kind of Business/Industry
d withir giene. r than the Me	ошо	Elementary/Secondary (0-12) College (1-4or 5+) Owne	r/Operator		Grocery Store/Bar
be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	· ·
hould I d Men marke matic	은	William Bernard Ridgell 19a. Informant's Name/Relationship (Type. Print) Grand- 19b. Mail	Agnes	Lillian I	
ind 2 salth an 27 is i		Anna Mae Dean / Daughter 1845	3 Windmill Point R	_	rden, MD 20630
ages 1 ant of He t: If item y or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetery, cre St. George	ematory or other place) July	3, 2008	Oc. Location - City or Town, State
mit. P partme portan y Injur			2. Name and Address of Facility	•	alley Lee, Maryland
o a m s		Muchoel Hardine	Mattingley-Gardiner F P.O. Box 270 Leonard		
		23a. Part . Enter the disease, or complications that caused the death. Do not enshible, or heart failure. List only the cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	Approximate Interval Between Onset and Death
Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Cardiogenic Consideration and the condition of the cond	Shock		1 Day
Examiner		1 SCINDING C	Cardiomyo	pathi	1 15 Tears
sit ad	ilner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.	J		
be executed ician and burial-transit	Examiner	resulting in death) Last C			
	-	d			
certifica ding ph	/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. For the Funeral Director: After this certificate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	in the nest 12 months?	□Ectopic pregnancy □ Other (<i>specify</i>)		23d. Date of delivery Month Day Year
that the	Ph	Page Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
equires en sign	ed ba	Diabetes mellitus		1 □ Yes	2 No 3 Probably 4 Unknown
2 33 23	Completed by	Hypertension		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
rsician: The law s certificate has t		<i>J</i> '			death? No 1 Yes 2 No
ysiciai is certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatie	Other:	n <i>(Check only one)</i> me 5 ☐ Residen	ce 6 Other (Specify)
ing Ph offer th uneral		27. Manner of Death 1 Avatural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how	
death.	icati	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	28f Location (Stre	et and Number or Rural Route Number,
ital or A	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my.knowledge, dea	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
To t To t	Σ	29b. Signature and title of dertifier	29c. License number	290	d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		onard town. MD 2065
		Thomas Annulis, M.D., 25500 Pe	pint Lookout K	oad Le	onardtown, MD 2065
Sta Registr		31. Date filed (Month, Day, Year) 32. Desistrar's Signature	Couls?		′
		OUL OF LOOD PORTED TO			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Vanessa Griffin Anne 310 JUNE 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomic PENINGULA DEGIDNA MEDICA Birthplace (State or Foreign Country) Date of Birth **Funeral** Months 1 □ M 2 🕱 F 219-86-6198 46 7/29/1961 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f shov Evanitive roust be notified at 1 ☐ Yes 2 ☑ No Director Wicomico Parsonsburg Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7010 Archie Dennis Road 21849 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 TMNo Specify white þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joyce Ann Webster Thomas Lee Phippin ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7010 Archie Dennis Rd., Parsonsburg, MD 21849 of Health Paul F. Griffin/husband or other 20b. Place of Disposition (Name of cemetary, cranatory or other place)
Oak Hall Riverside 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 7/3/08 Libertytown, MD 4 Donation 5 ☐ Other (Specify) Cemetery 2. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licensee 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5 drem disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of). Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE ate has been signed by the attending page 2 should be detached for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 1No 1 ☐ Yes 2 ☐ NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ⊟Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO041211 SAlisbury Md. 21801 TERNANO State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records.

08-04982 Kevin Hadle

A Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Arnold 4c. County of Death Anne Arundel Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) Foreign and Security Number of Service and number) Funeral			State of Maryland / Department 1- For State Certificate Registrar	of Death	Reg. No. 200	8 2307
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	Physici		1. Decedent's Name (First, Middle, La Megan Lucretia H	- /					M	ate of Deat fonth ne 27	Day V	3. Time or D	eath A M
	/Medio		4a. Facility Name (If not institution, giv		r)	-	4b. City, Town, o	r Location of			4c. County of		
			6405 Gallery Str	eet			Bowie				Prince	George's	
	Funeral		5. Social Security Number 6. S	Sex 7. A 1 □ M 2 X F	Age (In yrs. last b		If Under 1 Year Months Days	If Under 2 Hours	Min (A	ate of Birth Nonth, Day,	, Year)	Birthplace (State or I Country)	
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	/land ow at		10a. State 10b. County		10c. City, Tov	vn or Lo	cation					10d. Inside City	Limits
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	ter de items ner m	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces 1 \(\text{Yes} \) 2\(\text{A}	nt Ever in U.S. s? ∃No	13.	Was Decedent of F f Yes, specify Cub	lispanic Orig an, Mexican	gin? (Specify Y , Puerto Ric <i>a</i> n	es or No- , etc.)		American Indian, White, etc.	
36	ırs afi al", or xami	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			I∐Yes 2. ZANo	Specify:			Specify:	Black	
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Completed	15. Decedent's E	ducation	168	a. Deced	lent's Usual Occup	oation	of warking		16b. Kind of Busin		
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anc	d be fi	Be	Thomas Clarkson-W						ful Co		viaiden Surname)		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ပ္	19a. Informant's Name/Relationship (19	b. Mailir	ng Address (Street		-		r, City or Town, Sta	ate. Zip Code)	
S	s 1 and 2 soft Health and item 27 is		Gemina O. Archer-	Davies/ D	-		05 Gallei				-	.,,	
altimore,	es 1 a of Head Item		20a. Method of Disposition	70	l camet	of Dispo	sition (Name of natory or other pla	ce)	Date		20c. Location - Cit	y or Town, State	
<u><u><u></u><u><u></u><u><u></u></u></u></u></u>	Pages ment of I ant: If ite ury or of		1 XBurial 2 □Cremation 3 □ 4 □Donation 5 □ Other (<i>Specil</i>		Lak	emo	nt Gardens	7	/12/200	08	Davidson	ville, MD	
Balt	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licer	nsee			. Name and Addre	ss of Facility				neral Home	
_	90 = 40	_	man								, MD 207	_	
	Service.		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each	fine.	not ent	er the mode of dyi	ng, such as	cardiac or resp	piratory arre	est,	Approximate Interval Between Onset and De	een eath
	Physician / /Medical		disease or condition resulting in death)	Lung C		-6\-						Months	
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Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcom	ne pf pregnancy						23d. Date of	of dollivory	
	death atter	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🏋 No	4□Pregnant	2 Fetal deat at time of death		Ectopic pregnanc Other (specify)	у			Month	,	ar
P.O.	t the by the	hysi	9 Unknown	9□Unknown									
	ires that the de signed by the a i be detached i	by P	Part II. Other significant conditions of	contributing to death	but not resulting	in the ur	nderlying cause giv	en in Part I.	2	23e. Did tot	bacco use contribu	ite to the cause of dea	ath?
ord	w require been sig should b				· · · · · · · · · · · · · · · · · · ·					1 □ Ye	es 2 📉 No. 3[☐ Probably 4 ☐Un	known
ec	has be	Completed							2	4a. Was a autops	sy prio	re autopsy findings av	ailable se of
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or Vital Records,	Attending Physician: The r death. ector: After this certificate has the funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:			t 3□ DOA Oth	IOF:	of Death (Che				
o	Physer this eral di	7: To	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of In	tient 2 ER/O	Time of	· OLI DON	4 LI Nui			ence 6 Other	(Specify)	
ion	nding th. r: Afte e fune	tion	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	Day Year)	Injury		kî? Yes 2∐≀					
Division	Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	Zoe. Place of I	njury - At home, fa etc. (Specify)	arm, str	eet, factory, office			ocation (St		or Rural Route Numbe	9 <i>r</i> ,
	tal or rs afte al Di	Cert			oto. (oposity)					The second	i, diate)		
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Pt Certifying Pt Certifying Pt Certifying Pt	nysician: To the bes	of examination a	je, death nd/or in	n occurred at the ti vestigation, in my o	me, date and opinion, deat	d place, and de th occurred <i>a</i> t	ue to the ca the time, d	ause(s) and mann late and place, and	er as stated. d due to the cause(s)	
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	⊢≶⊢ŏ		· Val Var		_ M	D	DO	058	779			0,2008	
	Y		30. Name and address of person who	completed cause of		- 4			• •			(
7	C14		Carl Kasamon, M.D					cway,	Suite :	300,	Columbia	, MD 21044	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 1 2	008 32 egis	strar's Signature	d							

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Worken Event in the retified at once. Baltimore, Maryland 21215-0036 6-30-08 Hoses

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Sta Registra

				Certifi	nent of H cate of D	Peath		Reg. No.		
r, Decedents Name	e (First, Middle, Lasi	Louis Hod	les				2. Date of De Month June	Day 30	Year 2008	3. Time of Death 2120 M
a. Facility Name (I	If not institution, give	street and number)		4b.	City, Town, or	Location of D	eath	4c. 0	County of Death	1
	Suburban Ho	spital			E	ethesda			Mont	rgomery
5. Social Security N		x 7. Age	e (In yrs. last bir	Mo	Inder 1 Year nths Days	If Under 24 Hours M	Hrs. 8. Date of Bi	rth ay, Yea <i>r)</i>	9. Birti Cou	nplace (State or Forei untry)
060-28-4	179		74	Yrs.			June 1	9, 193	4	New York
Jsual Residence of Oa. State	10b. County		10c. City, Town	n or Locatio	n					10d. Inside City Limi
Maryland	Montgo	nery				Rockvi1	le			1 □Yes 2 x N
0e. Street and Nur				10	f. Zip Code			10g. Citiz	en of What Co	untry?
102	201 Grosveno	r Place, #60	1			20852			U.S	5.A.
1. Marital Status	,	12. Was Decedent E Armed Forces?		13. Was If Yes	Decedent of His , specify Cubar	panic Origin? , Mexican, Pi	(Specify Yes or Nuerto Rican, etc.)	0- 1	 Race - Amer Black, White 	
1 ☐ Never Marri 3 ☐ Widowed	ied 2 Married 4 □ Divorced	1 ∐Yes 2 🕱 N If Yes, Give Year or Dates:	lo		es 2⊠No	Specify:			Specific	Caucasian
(Spec	15. Decedent's Edu	ication le completed)	16a.	Decedent's	Usual Occupa of work done di	tion uring most of	workina	16b. Kin	d of Business/I	ndustry
Elementary/Seco	, , , ,	College (1-4or 5-	+)	life. DO N	OT use retired)	-	J		Padama1 1	Corroment -
7 Father's Name	(First, Middle, Last)	5+			Mathemat		Name (First, Middle			Government
r. ramers Name						io. Mothers i			ounanio)	
Oa Informenta M	Morris He ame/Relationship (7)		104	Mailina Ad	drace (Street -	nd Number -	Anna r Rural Route Numi	Magid	Town State 3	in Code)
					_					
Oa. Method of Disp	san Hodes - I	MITE	20b. Place of	f Disposition	(Name of		Date		ary rand ation - City or 1	20852 Fown, State
1 🔀 Burial 2	☐ Cremation 3 🗷 F 5 ☐ Other (Specify)		cemete	ry, cremator	y or other place orial Gar	i	7/02/2008			, Virginia
23a. Part 1 Enter the shoot, or hear mmediate Cause is disease or condition esulting in death) Sequentially list contains, to import any, leading to import any leading to import and import any leading to import any leading to import any leading to imp	nditions, imediate	a. Due to (or as a	the death. Do e. ulmon ar a consequence	not enter the	O New Han	pshire A		ver Sp	ring, Man	Approximate Interval Between Onset and Death
nat initiated events sculting in death) I FFEMALE: 3b. Was decedent	Last	d						2	3d. Date of deli	very
in the past 12 1 □Yes 2 □ 9 □ Unknown	months? □No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			opic pregnancy er (s <i>p</i> ec <i>ify)</i>				Month	Day Year
art II. Other signif	ficant conditions co	ntributing to death bu	it not resulting in	the underly	ing cause give	n in Part I.				the cause of death?
Tavana	cen heme	pathy,	we cubid	VC.	ricer		- 1	Yes 2□		obably 4 nknow
Acpirod	ion free	mexia /	Hypoth	groidi	(m		24a. Was auto perf 1 □Yes	opsy ormed?		topsy findings availat completion of cause o 2 □No
5. Was case reference examiner? 1 ☐ Yes 2 ☐	/ [1	Hospital:	nt 2 ☐ ER/Ou	utpatient a	□ DOA Othe	,	Death (Check only	one)		
7. Mann Deati 1 Natural 2 Accident		28a. Date of Injur (Month, Day	y 28b.	Time of njury	28c. Injury Work		28d. Describe			
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju building, etc	ry - At home, fa . (Specify)	rm, street, f	actory, office		28f. Location City or To	(Street and wn, State)	Number or Ru	ral Route Number,
		sician: To the best of iner: On the basis of and manner sta	examination ar							
29a. Certifier (Check only one)		- and mariner sta				mumb a v				
(Check only one)	title of certifier	el. Mo)		29c. License	62167			signed (Monti	n, Day, Year)
19b. Signature and	title of certifier	y. Mc		(Type, Print)	D 00					n, Day, Year)
(Check only one) 19b. Signature and 1 1. 1. 1. 1. 1. 1. 1. 1. 1.	AL	ch. MC	eath (Item 23a)		D 00	62167	, Maryland	7		n, Day, Year)

	-	For State Registrar	State of Mar		artment of H tificate of D		l Mental Hy	rgiene Reg. No. 2	008	2307	5
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Sam			Ha	•	2. Date of De Month	Day	Year 2008	3. Time of Death	_
Examine	_	4a. Facility Name (If not institution, give si The Johns Hopkins Ho 5. Social Security Number 6. Sex	spital	la um laat histhala ()	4b. City, Town, or Baltimore If Under 1 Year		re R Date of Bi	dh	ty of Death	place (State or Foreign	_
Funeral Director			M 2□F	41 Yrs. last birthday)	Months Days	Hours Mi		11, Year) 11, 196	7 Okla	place (State or Foreign try) ahoma	_
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show nit, the Medical Examiner must be notified at	Director	10a. State 10b. County Maryland Harfor		oc. City, Town or Lo	leen					10d. Inside City Limits 1 Yes 2 □ No	
th with th 23a or 2 ist be no	ral Dire		Apt. 1			001		10g. Citizen of	A		
36 s after dea , or Items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Even Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🔀 No	spanic Origin? n, Mexican, Pue Specity:	(Specify Yes or No erto Rican, etc.)	Spec	ace - Americ ack, White, e		
and 21215-0036 be filed within 72 hours after death with rital Hygiene. Indicate than "natural", or Items 23a of event, the Medical Examiner must be event.	Completed k	15. Decedent's Educ (Specify only highest grade	cation	(Give	dent's Usual Occup kind of work done o DO NOT use retired,	during most of v	vorking	16b. Kind of			_
nd 21:	Be Com	12 17. Father's Name (First, Middle, Last)	0		a Collec		Name (First, Middl		nology ^{ame)}	7	
arylc	2	Sam Edward Hall, S 19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street		Mae And		n, State, Zip	Code)	
of Heal		Sam E. Hall, Sr. 20a. Method of Disposition 15 Burial 2 Cremation 3 R	(father) emoval from State	20b. Place of Dispo cemetery, crer	natory or other plac	e)	erdeen, 1 Date 18/08	20c. Location	n - City or To		
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any Injury or other		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral South Scenser	Han lin	22	Cemeter Name and Address Derdeen,	ss of Facility T	arring-C	Church argo Fu 3399		Home, PA	_
Physician		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one immediate Cause (Final disease or condition	e cause on each line.	e death. Do not ent	er the mode of dyin	g, such as card	diac or respiratory			Approximate Interval Between Onset and Death 2 Wecks	
ficate be executed ficate be executed the burial-transit as the burial-transit field.	edical Examiner	resulting in death) Source tidally flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of):	repatit	2.0					
death certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	☐ Ectopic pregnance ☐ Other (specify)	у			Date of delive	ery Day Year	
uires that the signed by the lid be detach	ģ	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying cause gi	ven in Part I.		tobacco use co		the cause of death?	
II Records, The law requires that has been signer page 2 should be	Completed						24a. Was auto perl 1 🗆 Yes	opsy formed?	b. Were auto prior to co death? 1 \(\sum Yes	opsy findings available ompletion of cause of 2 No	
of Vital Physician: The this certificate and director, pa	Be	25. Was case referred to medical examiner?	lospital:		oth	OF:	Death (Check only		Dalle - 10 1		_
On of	ition: To	27. Mann of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yo	28b. Time o	of 28c. Injur	y at	g Home 5 ☐ Res 28d. Describe	how injury occ		y)	
Division al or Attending s after death. I Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury building, etc. (- At home, farm, str Specify)	eet, factory, office			(Street and Nu own, State)	mber or Rur	ral Route Number,	
Hospi 24 hou Funer tely fil	edical (sician: To the best of r ner: On the basis of e and manner state	kamination and/or in							
To the within 2 to the comple	Me	29b. Signature and title of certifier	nedical I	Doctor.	29c. License	= number \$ - 00	0	29d. Date sign			
		30. Name and address of person who co		ath (Item 23a) (Type,	Print)	60	0 North W	olfe St, E	Baltimo	re, MD, 2128	7
Stat Registra		31. Date filed (Month, Day, Year) JUL 1 7 200	32 Registrar's	Signature	all I						_

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 2008 **Physician** Edward W. Hooks 545 June 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Rehabilitation & Mursing Ctr. 5. Social Security Number 6. Sex. 7. Age (In vrs. last orthogon) Wicomico Salis bury If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Maryland 215-38-9587 80 Director 09-07-1927 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Wicomico Salisbury MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 314 South Haven Avenue Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No 21215-0036 Specify. Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Air Force <u>Communications Specialist</u> 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be n and Mental Goldie Reynolds Claude Hooks ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other tra 314 South Haven Ave., Salisbury, MD 21804 Myrtle Ann Hooks/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Bunal 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Beechwood Cemetery 07/03/2008 Princess Anne, Maryland 22. Name and Address of Facility Hinman Funeral Home Signature of Fyneral Service Licenses M00295 11673 Somerset Ave., Princess Anne, 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pus disease or condition resulting in death) cen /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1 Yes 2 No 1 Inpatient Certification: To After this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robins 10 M.D. State 3 2008 Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygien 🖓 🛭 🖯 🖰 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Vear 1409 /Medical 131 30 LYNDA MAE HOLLAND 2008 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6. Sex Salisbury
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Aug • 27, eninsula Medical Cont Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Vear 60 Director 1947 West Virginia 235-70-1316 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sho event, the "Medical Exemitar mast be redified at Director 1 ☐ Yes 2 X No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 Funeral USA Poad

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 4274 Jacksonville
11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No \$ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If item 27 is marked other the any Injury or other traumatic event, that once. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Van Meter Catherine (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clyde Holland (Husband) 4274 Jacksonville Road - Crisfield, Maryland 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory July 3, 2008 Salisbury, Maryland 21. Signature of Funera Service Censes

Mary Beth Bradsha 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hemmanha u disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Physiclan: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Month Day Year 5 ☐ Other (specify) 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown peen HTN 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a. Was an autopsy performed? this certificate 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 1 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation **V** ✓ Natural 2 Accident 1 □Yes 2 No atter death Director: by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 6319 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

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31. Date filed (Month, Day Ye

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Year 2 EASTERN

rar's Signature

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SHORE

21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23076 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2220 P.M Stong 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 13 | 07 | 09 | 200 | 8 9. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) 1 □ M 2 🗡 F Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21030 . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 No Specify: Specify: Koyean 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Flementary/Secondary (0-12)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

by Funeral

within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, In Medical Examinating the nuttles of

Baltimore, Maryland 21215-0036

and burialphysician a the burialattending p signed by the a has page 2 certificate

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

pel	15. Decedent's	Education	16a. Decedent's Usual Occupation	16b.	Kind of Business/Indust	ry
Completed	(Specify only highest g	rade completed) Callege (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)	rking		
то	Lientenaly/Gecondary (0-12)	College (1-401 54)	none		none	
BeC	17. Father's Name (First, Middle, La.	st)	18. Mother's Nat	me (First, Middle, Maide	en Surname)	
10 E	Stong Beon	n Jeana	Sue :	Jean Ch	DUNCA	
	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing Address (Street and Number or R	ural Route Number, City	or Town, State, Zip Co	de)
	Suc Chung-Mother /Sci	ong Jeong-Father	5 Firefly Circle AptM	Cockeysvil	12,MD, 210	30
1	20a. Method of Disposition		Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - City or Town,	State
	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	cify)Hcsp, mlL	DINA HOSPITAL /	9/08 X	Ja/tomos	ee, MI
	21. Signature of Funeral Service Lic		22. Name and Address of Facility	NA, HOSPI	THLOFBO	Himore
(A)	Leusa	Warks	- 2401 W. Belvebe	ec Ave. Ba	Himoec, HD	DZ1215
	23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused the dea ly one cause on each line.	th. Do not enter the mode of dying, such as cardia	c or respiratory arrest,	Init	proximate erval Between
	Immediate Cause (Final disease or condition	Prem	aturity		Or	nset and Death
	resulting in death)	Due to (or as a consec	quence of):			
_	Sequentially list conditions,	b				
ine	if any, leading to immediate	Due to (or as a consec	quence of):			
хап	Cause (Disease or injury that initiated events resulting in death) Last	c	guenea oft			
al E		Due to (or as a consec	quence or).			
dic		d				
/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancv		23d. Date of delivery	
ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of	al death 3 Ectopic pregnancy		Month Da	y Year
hysi	1 □Yes 2 No 9 □ Unknown	9 Unknown	, , , , , , , , , , , , , , , , , , , ,			
y P	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the c	ause of death?
Be Completed by Physician/Medical Examiner				1 ☐ Yes	No 3 Probabl	y 4 □ Unknown
plet				24a. Was an	24b. Were autopsy	
mo.				autopsy performed? 1 \Begin{array}{c} Yes 2 \Begin{array}{c} 1 \Begin{array}{c} Yes 2 \Begin{array}{c} 1 \Be	death?	etion of cause of No
3e (25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)		\
٥	1 Yes 2 No			Home 5 Residence	6 ☐ Other (Specify)	
on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of lnjury at Work?	28d. Describe how in	jury occurred	
cati	2 Accident investigati 3 Suicide 6 Could not	ho	M 1 ☐ Yes 2 ☐ No			
Medical Certification: To	4 Homicide determine	d 28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Re ate)	oute Number,
ia C			owledge, death occurred at the time, date and plac			
edic	(Check only 2 Medical Exa	aminer: On the basis of examination and manner stated.	ation and/or investigation, in my opinion, death occ	urred at the time, date a	ind place, and due to the	e cause(s)
Σ	29b. Signature and title of certifier	101111	29c. License number	29d. [Date signed (Month, Day	r, Year)
	MUNIV	WUVVV	12100 000-R	t) 7	111108	

State

Registrar

31. Date filed (Month, Day, Year)

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Sinai Hospital 2401 W Belvedere the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#1perMD7-2-08,BMW,MbCb Certificate of Death 2. Date of Death KII HONG **JEUN** Year Physician 0229 PM 06 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimore City Baltimore Mercy Hospital if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1**™**M 2□F 77 215-04-2114 South Korea 05,07,1931 Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a State 10h County 1 ☑ Yes 2 ☐ No Md Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20th Street S.Korea Apt.18T 21218 Funeral 11 West Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Specify: Asian 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Liquor Store 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Joo Bong Jeun Hee Park 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Jee Kim/Granddaughter 4309 Chancery Park Drive Fairfax, Va 22030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem 7/01/2008 Beltsville, Md. 4 Donation 5 ☐ Other (Specify 21. Signature of Juneral Service Live PHILIP D'RINALDI FUNERAL SERVICE, P.A. 9241 Columbia blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10 days Hepatic Adenocarcinomo Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an performed 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) ER/Outpatient 3 ☐ DOA ၉

Physician /Medical Examiner P.O. Box 68760 certificate be

Funeral

Director

28a-f show

"natural", or Items 23a or 28a-f shov edical Examiner must be notified at

Medical

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than

d 2 should be filed w h and Mental Hygies 7 Is marked other th

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, i

72 hours after

Baltimore, Maryland 21215-0036

burial-trar physician the attending signed by the a e Hospital or Attending Phys 24 hours after death. e Funeral Director; After this letely filled in by the funeral dil Certification:

Division or Vital Records,

examiner? 1 □ Yes 2 🗹 N	lo	Hosp	ital: 1 🗹 npatient	2 🔲 E
27. Manner of Death 1 Matural 2 ☐ Accident	5 ☐ Pending investigation	2	8a. Date of Injury (Month, Day Yo	
3 ☐ Suicide	6 ☐ Could not be	2	Se Place of injune	At hou

determined

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	1 M Certifying P 2 ☐ Medical Exa

4 ☐ Homicide

Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier onattion DE Golalo, MD 29c. License number P21202 29d. Date signed (Month, Day, Year) 06, 27, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Ekedahl 305 W. Fayette St. Apt. 1706 Baltimore, Md 21218

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 02 2008



To the Hospital ewithin 24 hours at To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 10:00 A M BERMAN JASSIE July 1, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7704 Geranium Street Bethesda Montgomery If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F 158-30-2753 August 12, 1940 Illinois Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I frem 27 Is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be marting and Injury or other traumatic event, the Medical Examiner must be marting. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7704 Geranium Street 20817 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Yes, Give Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemist Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ben Berman Sylvia Cohen 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Newton L. Jassie, 7704 Geranium Street, Bethesda, MD husband 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Bemoval from State Wellwood Cemetery July 2, 2008 | Farmingdale, New York 5 ☐ Other (Specify) Funeral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of 11800 New Hampshire Avenue, Silver Spring, MD 20904 23a. Part. Enter the saase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillur. List only one cause on each line. Immediate Cause (Fina disease or condition resulting in death) Physician OF METASTATIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Matural 5 Pending Injury To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Ar completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗜 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier englowing MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUARE DR. WHITE MARSH, MD. 21230

State

Registrar

C VERGAPA- SCAPES

JUL

2008

31. Date filed (Month, Day, Year)

9140 FRANKUN

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 8105PM aM UM 01 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner illag Talbot ton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F Months Days Hours 4650 Yrs. **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 Tes 2 No death with the Mar Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 12 Divorced Black Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the M Private Residence NorKer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be lalley rci ဂ္ Navgaret 19a. Informant's Name Relationship (Type, Print) 19b. Mailing Address (Street and Number or Horal Route Number, City or Town, State, Zip Code) St. Apt. 131 Easton, Phanie 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State avadi'se Cometery 08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY Funeral 21. Signature of Funeral Service Licensee Home, HENRY 510 washington Str Cambridge, MD. 21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed sician and burial-trans Due to (or as a consequence of) or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? jo Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9∏Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) Medical Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director; completely filled in by the 6 □Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier and manner stated. To the and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu) 0

State Registrar 30. Name and address of person who co

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

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of death (Item 23a) (Type, Print)

		,	For State Registrar		State	of Marylar	-	artment of I rtificate of				giene Reg. No. 20	08	23080
			Decedent's Nam	ne (First, Middl	le, Last)						2. Date of Dea	ath	.,	3. Time of Death
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· de	Examir		4a. Facility Name (n, give street and r	number)		4b. City, Town, o	or Location	n of Death		4c. County	of Death	
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	Funeral		Social Security N		6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs.		If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthp Coun	lace (State or Foreign try)
	Director		578-88-5 Usual Residence of			66	Yrs.				February	26,1942		India
	and and		10a. State	10b. County		10c. Ci	ty, Town or Lo	cation					10	Od. Inside City Limits
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ita Medical Exartinal remust be notified at once.	Funeral	11. Marital Status	•		cedent Ever in U	.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic C	origin? (Sp	ecify Yes or No	14. Rac	e - Americ	
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altimore,	it Printing in internet	1	4 ☐ Donation 21. Signature of Fu			\A1		Cemetery 2. Name and Addre	ess of Faci		3/2008	Germant	own, M	aryland
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O. B	death e atte	icia	in the past 12 1 ☐ Yes 2	months? ☑No	4 □ Pre	e birth 2□Feta egnant at time of o] Ectopic pregnand] Other <i>(specify)</i> _	cy			Mo	onth	Day Year
P.O.	t the by th	Physician/Me	9 ☐ Unknown		9 🗆 Uni	known								
ecords, P.	w requires that the death certify been signed by the attending I should be detached for use as	by P	Part II. Other signif	ficant condition	ons contributing to	death but not res	sulting in the u	nderlying cause giv	ven in Part	t 1.	23e. Did te			e cause of death?
कू हूं	quire an sig uld b	be pe									1 🗆 1	es 2 No	3☐ Prob	ably 4 🗍 Unknown
Records,	sw re	Completed									24a. Was		Were auto	osy findings available
3 c	The law tehas age 2 s	E									autor perfo 1 □ Yes	rmed?	phor to cor death? 1 □ Yes	npletion of cause of
Vital	Prysician: The law r this certificate has b ral director, page 2 st	Be C	25. Was case refer	red to medical	ı	·			26. Plac	ce of Deat	h (Check only o		10163	20110
ا کالی	ysici is cel direc	To B	examiner? 1 ☐ Yes 2 🔀	No	Hospital:	npatient 2] ER/Outpatier	nt 3 DOA Oth	ner: 4 🗆 N	Nursing Ho	ome 5 ☐ Resid	ience 6 🗆 Oth	er (Specif	()
100	ding Fin h. After thi funeral (<u> </u>	27. Manner of Deat		28a. Dat	te of Injury onth, Day, Year)	28b. Time of Injury		ry at		28d. Describe I	ow injury occur	red	·
23 A(A) Division	death. ctor: Af y the fur	atio	1 Natural 2 ☐ Accident	5 ☐ Pendin investi	gation	, = =,, . = =.,	,,		Yes 2	□No				
S iv	er de recto by th	iii	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	not be nined 28e. Plac buil	ce of Injury - At he	ome, farm, str	eet, factory, office			28f. Location (5 City or Tov		er or Rura	l Route Number,
70	Hospital or Attending 44 hours after death. Funeral Director: After tely filled in by the funer	Certification:			6					- 8				
	Hospita 24 hours Funeral etely filled		29a. Certifier (Check only	1 Certifyir	ng Physician: To the Examiner: On the	he best of my kno	owledge, deat	h occurred at the t	ime, date a	and place,	and due to the	cause(s) and m	anner as s	tated. the cause(s)
		Medical	one)			anner stated.								
- 4	vithin To the comple	≥	29b. Signature and	title of certific	24	00		29c. Licens		-		29d. Date signe		
	12		1 Tai	47	Goint	20		DOE	0010	083	7	JUNE	30/	2008
			30. Name and addr	ess of person	who completed ca	use of death (Iter	m 23a) (Type,	Print)	3.0.0				- 4	2000
			PALL /4	HAMB	1, 470			VR, TT	700°	, K	3CK 11	ue, 1	41) e	20850
	Sta		31. Date filed (Mon		2000	Registrar's Signa	ature	. At 16						
	Registr	ar	JUL	022	בטטט איני	we B	600							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23081 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician ^{Day} 2008 Month Richard Bernard Kassin 27 June 11:20 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Montgomery Rockville 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 X M 2 □ F Director 466-30-8394 80 Michigan June 8, 1928 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notifled at Director 1XYes 2 No MD Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 9600 Napoleon Way Funeral 20886 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1945— Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1946 & 1 ☐ Yes 2x No ò Specify: White 3 Widowed 4 Divorced 1948 - 1950 Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any Injury or other traumatic event, the once. 12 Management Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 Louis Kassin Grace Ihrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jodi K. Kern - Daughter 12521 Milestone Manor Lane Germantown, MD 20876 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 6/29/08 Clarksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Metastatic Mesothelioma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Physician/Medical 98 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year 4□Pregnant at time of death by the a 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page autopsy performed' 1∐ Yes 2K No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice Hospital: 1 ☐ Yes 2 💢 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 🔀 Natural Injury To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A 1 Tyes 2 Accident 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide in by 1 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ☑ Certifying Physician: To the best-of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.O. Box 68760 Division or Vital Records,

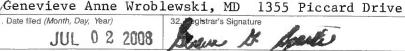
State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 0 2 2008

and title of certifier

29b. Signature



us 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

D64615

29d. Date signed (Month, Day, Year)

June 28, 2008

Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23082 State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** June 29 2008 1:30 PM Sherwood Edward Lake /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis HealthCare - The Pines Talbot Easton Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Months Days Hours 1 DXM 2 □ F Director 23, 1955 220-66-2666 53 Maryland Jan. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ral", or tems 23a or 28a-f shov Examiner must be notified at Dorchester MD Hurlock 1 ☐ Yes 3€ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4844 Milligantown Road 21643 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Married herwood Lake timore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by Specify: black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) janitor state government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Percy J. Lake Mabel Jones ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Lake P. O. Box 54, Woolford, MD sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Pleasant Churchyard 7/5/08 4 Donation 5 Other (Specify) Salem, MD 22. Name and Address of Facility Thomas Funeral Home P.A. Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Year Month Day signed by the at d be detached for 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe page 2 No 2 No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: ၣ 1 Yes 2 No 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral dir After this 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 12 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (item 23a) (Type, Print) GIO DUTCHMAN'S LANG ROWLLY

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23083 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month July 1 2008 4:40 p.m. John Graham Lancaster 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In vrs. last birthday) 90 01/31/1918 Virginia 230-40-9687 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 ☐ Yes 2 X No Maryland | St. Mary's California 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20619 44032 Flagstone Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No 3 Widowed 4 ☐ Divorced **Black** 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Agriculture Agriculture Extension Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Moss John Wesley Lancaster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Corwin Street, Apt. #6, San Francisco, CA 94114 John Lancaster/Son Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Oddfellows Cemetery | 07/10/2008 | Farmville, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Experal Service Licenson
Edward N. Brinspield, 20650 Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): erra Due to (or as a consequence of): Gasters Due to (or as a consequence of):

Physician /Medical Examiner

burial-tra

Physician/Medical

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Certification:

Medical

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Department o Important: If any Injury or = 5

Pages 1 ⊓ent of t

Physician

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show r 28a-f show notified at

ms 23a or must be n

th and Mental Hygiene.
7 is marked other than "natural", or items traumatic event, the Medical Examiner mu

Saltimore, Maryland 21215-0036

Vital

Division

death with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

> IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I.

performed 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes B☐ No 27. Manner of Death

Hospital: Impatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

29a. Certifier (Check only

Natural

2 Accident

3 ☐ Suicide

4 | Homicide

1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of

5 Pending investigation

6 ☐ Could not be determined

M.D.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D 60888

26840 Point Lookout Road, Leonardtown, MD 20650

29d. Date signed (Month, Day, Year) 07/02/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakhi Krishnan, M.D. 31. Date filed (Month, Day, Year)

JUL 0 7 2008

32. Registrar's Sign

State Registrar

24 hours

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 23084 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 2008 12:25 p June 28, Physician Leslie Kathleen Miles /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 10 Pimlico Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Months Days **Funeral** Florida 1 □ M 2X□ F 1917 16. Oct. 90 264-28-5301 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State or Items 23a or 28a-f show 1 ☐ Yes 2 ☐XNo the Medical Examiner must be notified at Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20906 10 Pimlico Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or Iter any injury or other traumatic event. The Martinal Ferr 1 ☐ Never Married 2 ☐ Married SpecifiWhite 1 ☐ Yes 2 ☑ No Specify. ð 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) within 27 is marked other than "n traumatic event" College (1-4or 5+) Elementary/Secondary (0-12) Own Home 5+ <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Dora Pippin Percy Web Miles 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28A Lee Street, Cambridge, Massachusetts 02139 Donald M. Leslie, Jr./Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Purial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 7, Parklawn Memorial Park 2008 Rockville, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licens 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final years Arteriosclerotic Cardiovascular Disease **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal deal

4 Pregnant at time of death Year 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day 2 Fetal death in the past 12 months? 5 Other (specify) □Yes 2□No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🛣 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? this certific al director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient ۴ 28d Describe how injury occurred Injury at Work? 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: After Injury 5 Pending investigation 1 X Natural 1 ☐Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after deatl To the Funeral Director: completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 30, 2008 D08381 cause of death (Item 23a) (Type, Print) on who completed 30. Name and address of per 18111 Prince Philip Drive, #209, Olney, MD 20832

21215-0036

State Registrar 31. Date filed (Month, D ear) 2008

Benjamin Avruhin, MD



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 8:55 A 26 Teresa C. Littleton 06 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** If Under 1 Year Wicomico Hospice Lake 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 👿 F 57 Director 222-38-4140 May 13, 1951 Delaware Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ₹ No Director DE Sussex Laure1 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 10012 Camp Road 19956 A .

14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. em 27 is marked other than 12 2+ Volunteer/Aide Charity/ School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glen Cordrey ပ္ Inez Cordrey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Littleton / Husband 10012 Camp Road Laure1, Delaware 19956

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Odd Fellows Cem. 6-30-2008 Laurel, De. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West St. 23a. Part1. Entertile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hannigan, Short, Disharoon F.H. Laurel, De. 19956 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Testelle /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-tran Due to (or as a consequence of): Box 68760, requires that the death certificate be Physician/Medical as t attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has b page 2 sl autopsy perform certificate or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P After this funeral 27. Manner of eath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) Natural Accident Injury 1 ☐ Yes 2 ☐ No death. To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Guall State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Decedent's Name (First, Middle, Last) June **Physician** arolyn Marie 30,2008 1950 1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico Salisbury Rehab & Nursing Ctr. lisburg 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Year 1 □ M 2 ▼ F Months 217-52-2487 9/29/1950 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Ves 2 No MD Porlin Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21811 U.S.H Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify \$ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Department Dermit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other treasment. rative 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Hammond rockmood ပ္ oreman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5724 Blake Snow Hill MD Ursula Lockwood/daughter R9 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/5/2008 Williams A.M.E Newark, MD 4 Donation 5 Other (Specify) 21-Signature of Full III Service Livensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 Approximate Interval Between Onset and Death 23a. Part f. Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause of scholars. Immediate Caus Final disease or condition resulting in death) **Physician** 02 000 /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1□ Yes 2 3 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 No Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 aturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔾 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Lwood

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State Registrar William

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robins,

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JUL 0 2 2008

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Dorothy Laura McKenzie June 27 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Crofton Anne Arundel Crofton Convalescent Center 8. Date of Birth Jan. 20, 1915 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2□ Min. Months Days Hours 374-16-2757 93 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1006 Tallwood Road, Apt. T-A 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Mazza Tda Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1702 Forestville Road, Edgewater, Md. Susan Smith/Daughter 20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Washington Nat. Cem 7-1-08 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home f Funeral Service Liceprsee 2973 Solomons Island Road, Edgewater, Md. 21037 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part . Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years Conges Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Veal Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Was ar. autopsy performed? Ves 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner?

26. Place of Death (Check only one)

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other:

1 🗌 Yes

2 🗌 No

28c. Injury at Work?

3□ DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a, State

Director

Funeral

Completed by

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If tiern 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed ysician and e burial-trans Division or Vital Records, P.O. Box 68760,

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After this certificate has been signed by the uneral director, page 2 should be detached on: To Be Completed by Physic	whiting 24 inclusions rater users. The ribis certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but completely filled in by the funeral director, page 2 should be detached for use as the but Medical Certification: To Be Completed by Physician/Medical
After this certificate has been sign uneral director, page 2 should be uner. To Be Completed by	s are Director: After this certificate has been sign and in by the funeral director, page 2 should be actification: To Be Completed by
uneral director, page 2	s area focus. an Director: After this certificate ha of in by the funeral director, page. Certification: To Be Comp.
After this cuneral dire	al Director: After this can in by the funeral director.
	al Director: ed in by the

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State	
Registrar	

31. Date filed (Month, Day, Year) JUL 0 1 2008

29b. Signature and title of certifle

2 No

5 Pending investigation

6 Could not be determined

erez

1 Yes

27. Manner of Death

Natural

3 Suicide

29a. Certifier (Check only

one)

2 Accident

4 Homicide

death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

06/30/2008

2225E Defense Hry, Crofton, moz1114 30. Name and address of person who completed cause of MU

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June John C. Malloy 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Prince George's Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 21, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Year) 1936 **Funeral** Months Days Hours Min. 1 XM 2 ☐ F Pennsylvania 71 Aug. 567-42-8668 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at once. 1 X Yes 2 □ No Director Maryland Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code USA 20720 14002 Tollison Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: Unknown 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 XNo Specify <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Association Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary J. Fowler ျှ Herbert W. Malloy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14002 Tollison Drive Bowie, MD 20720 Nancy B. Malloy/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 7/1/2008 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRobert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate base. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part I bther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ icate has been sig ; page 2 should b 2 🗌 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ER/Outpatient 3 DOA 1 Tes 1 Inpatient Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of ear 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Netural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check on dical Examiner: one) nd manner stated. e and title of 29d. Date sign 29b. Signaty

State

DHMH 17 Rev 1/2001

Registrar

Name a

31. Date filed (Month, Day,

Year)

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1 2008

cause of death

an/01/

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 For State Registrar 23089 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Martin Nathan Ray 2008 10:05 P.M July /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Smithsburg 11219 Kieffer Funk Rd. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 22,1950 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 172 M 2 □ F Months Hours Min. Director 58 220-58-2575 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f sh Examiner must be notified Director 1 ☐ Yes 2 ☑ No Md. Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11219 Kieffer Funk Rd. 21783 U.S.A items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married Married 2**X** No 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer the Farm is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be I Mervin J. Martin Catherine M. Eshleman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:0 Department of Health at Important: If item 27 is any Injury or other trau Rebecca J. Martin (Wife) 11219 Kieffer Funk Rd. Smithsburg, Md. 21783 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stouffers—Pondsyille
Mennonite Church Cem 20a. Method of Disposition 20c. Location - City or Town, State Date t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 14, Cem. 2008 Smithsburg, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 Lee_ AV15 MO1414 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** can /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy certificate perform 1□ Yes 2 No Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 | Yes 2 | No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 1 Matural 5 Pending investigation after death 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 29b. Sigr 29c. License number 29d. Date signed (Month, Day, Year) nd address of person who completed cause of death (Item 23a) (Type, Print) 2291 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 2008 Registrar

1/2

DHMH 17 Rev 1/2001

08-05285

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Lester L. Metz 2008 23090 1- For State Certificate of Death Reg. No. Registra 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 9, 2008 1549 hrs **Medical Examiner** Lester Τ., Metz c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Clear Spring 13834 Clear Spring Road 9. Birthplace (State or Foreign If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** ^{Country)} Florida Days Months Hours 01/03/1955 267-19-4955 53 Director 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No Franklin PA Chambersburg s 23a or 28a-f show e notified at once. 28a-f show Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 144 Colonial Drive 17202 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death wir ment of Heath and Mental Hygiene, tant: If item 27 is marked other than "natural", or items; or other transmatic event, the Medical Examiner must be a per other transmatic event, the Medical Examiner must be a White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 X Married 1 X Yes white Specify: Yes 2 X No specify: If Yes. Give Year Divorced þ 16h Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pool Company Laborer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert Metz Charlotte Hepfer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 144 Colonial Drive, Chambersburg, PA. 17202 Melissa Metz 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 07-14-2008 Baltimore, crematory or other place) 1 XX Burial 2 Cremation 3 Removal from State Chambersburg, PA. 17202 Grindstone Hill Cemetery Donation 5 Other Specify 22. Name and Address of Facility J. L. Davis Funeral Home M01414 21. Signature of Funeral Service Licensee effery hec 12525 Bradbury Ave., Smithsburg, Maryland 21783 23a. Part I. Ente/ the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physiciar Between Onset and failure. List only one cause on each line. /Medical Death a. Electrocution complicated by Drowning Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical tending physician a AMENDED UNPENDED The law requires that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown . the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ Yes 2 ✔ No 3 Probably 4 Unknown ٦ Cardiomegaly Completed Records, 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of has death? page 2 s performed? Yes 2 No ✓ Yes 2 No certificate 26.Place of Death (Check only one) this certifi Division of Vital Hospital or Attending Physician; 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 ပ္ 1 V Yes No 28a. Date of Injury (Month, Day,Year) FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b Time of Injury 28c. Injury at Work? After Subjected electrocuted in pool FOUND: 1 Natural 1 ✓ Yes 2 No Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f 1530 hrs Jul 9, 2008 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 13834 Clear Spring Road, Clear Spring, MD determined (Specify) Swimming Pool Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. July 10, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July Day 2008 Year **Physician** Westbrook Nichols 9:15 a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartland House Grasonville Queen Annes If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF Months Days Hours Min. 216-14-9985 95 Director May 12, 1913 Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Grasonville 1 ☐ Yes 2 No Director MD Oueen Annes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Perry's Corner Road 21638 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2/☐No Specify. Specify: white Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) seamstress garment mfg. 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan Westbrook Caroline Fauth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aaron Harmon grandson 5339 Chateau Road, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. 7/5/08 East New Market, MD e of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. .Ic. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode, if dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 70mn /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an autopsy nerformed' 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) assisted 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To living 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

death certificate be executed P.O. Division or Vital Records, Hospital or Attending Physician: "naturai", or items 23a or 28a-f shov idical Examiner must be notified at

e filed within 72 hours after death with ia l Hygiene. other than "natural", or items 23a or ivent, the Medical Examiner must be n

Baltimore, Maryland 21215-0036

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permit. Page Department of Important: If any injury or

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Director: After this certific

within 24 hours aft

To the Funeral Di

completely filled in

29b. Signature and title of certifier

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30. Name and add

To the within 2

other t : If item or othe

State

Registrar

302 Colliks

and manner stated.

ess of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 30, June 2008 George Neal Sr. 9:12p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 15009 Schall Road Accokeek Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□ F 85 Hours Director 578-28-3362 Maryland 05/12/1923 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits be notified at Director 1X Yes 2 □ No Maryland Prince Georges 28a-f Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or items 23a 15009 Schall Road 20607 USA Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: Black 3 X Widowed 4 ☐ Divorced er than "nature, Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Custodian Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 36 William ဂ္ Annie Savoy Neal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Neal Jr./ Son 15009 Schall Rd. Accokeek, Maryland 20607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Clinton, Maryland Resurrection 7/7/08 22. Name and Address of Facility 21. Signature of Frideral Service License Adams Funeral Home PA 19120605 Aguasco Rd. Aquasco, Maryland 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions con libuting to death but not resulting in the inderlying cause given in part I. signed 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Sec autopsy performed? res 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No P 1 Inpatient 2 ER/Outpatient 3 DOA this s after death. completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature a title of certifi 29d. Date signed (Month, Day, Year)

State Registrar DAN

31. Date filed (Month.

DHMH 17 Rev 1/2001

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician June 29, 2008 6:20 A Theron Thrower Newsome /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, Y if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) 5. Social Security Number **Funeral** Hours Months Days 1**X**XM 2□ F 1927 Florida 80 264-30-3719 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Directo Maryland Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20602 USA 1204 Marshall Lane Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White þ Year or Dates: 1963 - 1966 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Navy Hospital Corpsman 12th. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Thrower ပ Cecil Newsome 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1204 Marshall Lane, Waldorf, Maryland, 20602 Linda Newsome/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Sept. 4, 2008 Arlington, Virginia Arlington Natl. Cem. 4 Donation 5 DOther (Specify) 22. Name and Address of FacilityHuntt Funeral Home $\omega_{\mathfrak{p}035}$ Old Washington Rd. Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed Ĉί for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sign, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2☑No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Certification: To 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation ospital -.4 hours after de... ---neral Director: Andre -'in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direcompletely filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 08 06 30 Name and address of person who completed cause 31. Date filed (Month, Day, Year) JUL 0 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 6 **Physician** 2300 PM ncere /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talkot asto aston DSPITEN ernoria If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month) Day. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1XM 2□ F Months aryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No amor Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21613 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumate. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ack 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephanie inder aul 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Slacum bridge, MDal613 tephanie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Lo atim - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cambridge MidShore Cremation * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Janelle C. There Henry Funeral Home P.A.

23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause (Final disease or condition resulting in death) Pnysician extreme /Medical Due to (or as a consequence Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 00 1 atient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

I or Attending Physician: after death. Director; After this certifice To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral

6 Could not be determined 3 ☐ Suicide

4 Thomicide

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number City or Town, State)

Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of continue 149

29c. License number

29d. Date signed (Month, Day, Year)

21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Saad Abdel-Gawad 828 Airpax Road, Building B, Cambridge, MD

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert Ashton Poetzman 30 2008 June 9:37 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 2060 Quaker Way, Unit 1 Annapolis Anne Arundel 5. Social Security Numbe 577–07–4784 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 23, 1 9. Birthplace (State or Foreign Funeral XXM 2□ F Months Days Hours Min. Director 94 1913 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho. The Medical Examinar ir ust be notified at Maryland Anne Arundel Annapolis Director 1 ☐ Yes 20 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2060 Quaker Way, Unit 1 21401 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the "Medical Examinar Insist once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes 2 A No Specify: White ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Office Supplies and Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John K. Poetzman Irma E. Groves ဥ 19a. Informant's Name/Relationship (Type. Print)
Dorothy League/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2060 Quaker Way, Unit 1 Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 7/3/2008 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal uner Jenice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Coronary Artery Disease years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day signed by the a 1 ☐Yes 2 ☐No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ icate has been si ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **X**No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2**XX**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No npletely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and P.O. Box 68760, Division of Vital Records,

the Maryland

Baltimore, Maryland 21215-0036

Medical To the within 2

24 hours a

Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifie

Michael J. LaPenta

21438

**Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 6-30-2008

30. Name and address of person was completed cause of death (Item 23a) (Type, Print)

445 Defense Highway Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JUL 0 1 2008

aistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25,27,28a-f, perME,8881 7/24/08 TT
State of Maryland / Department of Health and Mental Hygiene 1- State Amended itmes 20b.&20c,7.2.08 Certificate of DeathwichD, SLU Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 340 M Alice Marie Phillips | JUNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomu SALISBURY PENINGULA BEGIONAL MEDICAL Birthplace Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday Social Security Number **Funeral** Year) Months Days 1 □ M 2 F Hours Director New York Nov.2, 1914 060-09-6310 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b County 28a-f show Examiner must be notified at 1 Yes 2 □ No Director DE Seaford Sussex 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 5 items 23a 9927 Middleford Road U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, I'm Medical Examples once. 19973 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White Specify: Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Librarian Elementary Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma A. (Hauser) Louis A. Benson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9927 Middleford Rd., Seaford, DE 19973 Roy E. Phillips / Son 20c. Location - City or Town, State Lewes, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Pine, Lawn Military Gemetery Eastern Shore Crematorium 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Service Service Parsell Funeral Enterprises, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hyper fer 50 or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami physician and the burial-trans Due to (or as a consequence of) Box 68760. I or Attending Physician: The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the burian. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 1 □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐Yes 2 No 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XYes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d Describe how injury occurred on rug and Natural 5 Pending investigation 1 ☐ Yes 2 No Accident 6/29/2008 unk fell. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Boute Number City or Town, State) 9927 Middleford Rd filled in by 4 ☐ Homicide Home Seaford, DE 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29c. License number HJDU97 29b. Signature and title of certifi DO041211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. SAlisbury Md. TERNANDO J. AC/E 31. Date filed (Month, Pay, Year) 1008 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>08</u> Month July Lee Patricia 08 Robertson 11:55 aff 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 21276 Lexwood Court, Apt. 8A St. Mary's Lexington Park 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 M 2 AF 215-46-3820 63 12/05/1944 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland | St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21276 Lexwood Court, Apt. 8A 20653 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Christopher Robertson Lillian Ann Bean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Ann Knight/Sister 20777 Poplar Ridge Road, Lexington Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Face Church Cem. 07/12/2008 Great Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Moneral Service Licensee 22. Name and Address of Facility 23. Brinsfield Funeral Horn Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any series of the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 1 ☐Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

physician

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be 2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventual Process.

Examiner burial-tran Physician/Medical as the the attending p Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be ၉

detached

this certificate has I

27. Manner of Death Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2 No 9 ☐ Unknown

25. Was case referred to medical examiner? 2 No

5 Pending investigation

6 ☐ Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 \(\text{Nursing Home} \) 5 \(\begin{array}{c} \text{Residence} \) 6 \(\text{Other} \) (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only one) 29b. Signature and title of certifier

29a. Certifier

1 ☐ Yes

1 Natural 2 Accident

3 Suicide

4 Homicide

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avani D. Shah, M.D. 22650 Cedar Lane Court, Leonardtown, MD 31. Date filed (Month)

State Registrar

2008

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SCOE 03:05AM 22 2008 JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Dec 31 1935 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Maryland 72 218-28-2466 Director Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10b. County 28a-f show must be notified at 1X Yes 2 □ No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 23a or 2 21401 USA 73 Pleasant St. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or any injury or other traumatic event to once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 🎇 No Specify: B1ack Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cab Driver Reliable Cab Co. 10th n 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glendora Parker Roscoe Siscoe Sr. ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 73 Pleasant St. Annapolis, Md. 21401 Locricha Siscoe(Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Maryland Veteran 6-30-08 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Miname Research Collissons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ESPIRATOR Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): THEROSCI **Examiner** 2.0 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) d by the at detached f 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? page 2 has 2 X No 1 ☐ Yes 2X No 1 TYes certificate 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Hospital: 1 X Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA မှ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗷 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospitai 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Funer completely fi Medical (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

Registrar

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31. Date filed (Month, Day, Year) JUL 0 1 2008

ans

~10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

RES - 000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 23099 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 4:30 AM 30 neodosia 2008 June 4a. Facility Name (If not institution, give street and number) 4c. County of Death Styart e George 9. Birthplace (State or Foreign Country) Maryland Prince LAne 8. Date of Birth (Month, Day, Year) 06/01/1909 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2**X** F Months 99 217-36-5494 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14210 Gibbons Church Road 20613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Slater unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23202 Neck Rd.Aquasco, Maryland 20608 Robert Hawkins/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Thomas 7/5/08 Baden, Maryland 22. Name and Address of Facility Adams Funeral Home PA 21. Signature Fufferal Service Licensee 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AThenosclereti disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions in any, bearing to minimum action cause. Enter Underlying Cause (Disease or injury Due to for se's coneacuance off that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 2 No 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury

Physician /Medical Examiner The law requires that the death certificate be executed

Examiner

Physician/Medical

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Completed

Be

Certification:

Medical

State

Registrar

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

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Director

Funeral

Completed by

Be

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should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show

of Health and Mental I item 27 is marked or

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun once.

3altimore, Maryland 21215-0036

attending physician and for use as the burial-trar been signed by should be detac

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

25. Was case referred to medical examiner?

27. Manner of Death

2 Accident 3 ☐ Suicide 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

6 ☐ Could not be

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

045365

29d. Date signed (Month, Day, Year) 06-30-2008

> M. O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Siderans min 1170/ 1/2 ing Stor au # 101 ft WAShington MD 20741 MICH AGL

31. Date filed (Month, Day, Year)

JUL 0 2 2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene? [] [] § Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vesi **Physician** 8:A. JANE 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ANNAPOLI NRC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/05/1934 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2X F Yrs. West Virginia 74 227-40-0476 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State •how r 28a-f ehow 1 ☐ Yes 2 🕅 No Directo Maryland St. Mary's Lexington Park 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code rthen "natural", or items 23a or the Medical Examiner must be United States 20808 Red Rose Court 20653 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Maryland 21215-0036 Specify Specify: þ 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Secretary of Health and Mental Hygie fitem 27 is marked other t r other traumatic event, the other t permit. Pages 1 and 2 should be file.
Depenment of Health and Mental Hygis
Important: if lies 27 is marked
eny injury or other 12. 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Cecil Clear Mattie Mae Oaks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 20808 Red Rose Court, Lexington Park, MD 20653 Anita Long/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cre 07/11/2008 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signatural Salvice tion Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each link. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ol) Examiner or Attending Physician: The law requires thet the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day ģ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2001 1 ☐ Yes Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner Hospital: Other: 1 ☐ Yes 2 ☐X60 2 1 Inpatient 2 ER/Outpatient 3 DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M death. Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 Thomicide after within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier g W. O 30. Name and address of 23a) (Type, Print) OAV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		For State Registrar	State of Marylar		artment of F		d Mental H	lygiene Reg. No	200	8 2310	
, Physicia /Medica	n	1. Decedent's Name (First, Middle, Last) Joan Wickham		Spi	nning		2. Date of Month	Da	ay Year 2008	3. Time of Death 6:10 P	1
Examine Funeral Director	r	4a. Facility Name (If not institution, give some factors of the proton o	2	last birthday) Yrs.	4b. City, Town, or Potomac If Under 1 Year Months Days	If Under 24 I	eath	4c	County of Deal	ry hplace (State or Foreig	חק
TO O	ctor	Usual Residence of Decedent	10c. Cit	y, Town or Lo	cation		1-27		tizen of What Co	nsylvania 10d. Inside City Limits 1 本Yes 2 □ No	
ter death v items 23a iner must	<u>a</u>	10714 Potomac Tenn 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Noivorced 15. Decedent's Educ (Specify only highest grade	2. Was Decedent Ever in U Armed Forces? 1 Yes No If Yes, Give Year or Dates:	16a. Deced	20854 Nas Decedent of H f Yes, specify Cuba □ Yes 2□ No lent's Usual Occup kind of work done to NOT use retired	Specify:		No-	14. Race - Ame Black, White Specify: Wh Kind of Business/	rican Indian, e, etc. ite	
arylan S should be and Mental is marked of aumatic eve	0 De	17. Father's Name (<i>First, Middle, Last</i>) Ronald Spinning 19a. Informant's Name/Relationship (<i>Typ</i>)	4 De. Print)		g Address (Street	Mary W and Number of	r Rural Route Nur	dle, Maider	or Town, State, 2	Zip Code)	
Baltimore, IM permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tr		Charles Wright /Son 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 X R 4 □ Donation 5 □ Other (Specify) 21. Signature of Fluneral Service License	emoval from State Nat	Place of Disponentery, cremetery, cremeter, cremetery, cremetery, cremetery, cremetery, cremetery, cremeter, cremetery, cremeter, creme	Belt Rd sition (Name of natory or other place Crematory . Name and Address 130 Wisco	y 07/	Date 02/2008 Joseph G	Fall awler	ocation - City or Is Churc 's Sons	h, VA Inc.	
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Chronic Inf Due to (or as a conseq Chronic Inf Due to (or as a conseq Chronic Inf	uence of): ection	er the mode of dyin	g, such as car			igeon, D	Approximate Interval Between Onset and Death 10 Days More than 2 Years	
hat the death certif d by the attending letached for use as	r II yarcıdılı ivie	IF FEMALE:	Late Effects 3c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown tributing to death but not resi	incy I death 3⊑ eath 5⊑	Ectopic pregnancy Other (specify)	,		-	23d. Date of del Month	ivery Day Year	
The law ate has b page 2 st		Dysphagia, Chronic	o Obstructive	Pu1mo:	nary Dise		24a. W. au pe 1∐ Yes	as an topsy rformed? s 2K No	24b. Were au prior to death?	obably 4 □Unknown ttopsy findings available completion of cause of 2 □ No	_
r Attending Phy for death. Irector: After this in by the funeral d	2	examiner?	28a. Date of Injury (Month, Day Year) 28e. Place of injury - At houilding, etc. (Specifications)	ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 🗆	er: 4 🗷 Nursin		esidence e how inju	ry occurred and Number or Ru	ural Route Number,	
he Hospita in 24 hours he Funeral pletely filled		one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wiedge, death tion and/or inv	estigation, in my o	pinion, death c	ace, and due to the control at the time	ne cause(s ne, date an	s) and manner as d place, and due	stated. to the cause(s)	:1
vith vith Com		30. Name and address of person who cor				9	a MD 20	June	ate signed (Month		
State Registra		Susan J. Miller MD 31. Date filed (Month, Day, Year) JUL 0 2 2008					a, MD 20	7014			

DHMH 17 Rev 1/2001

			State of Maryland / Dep	artment of Health and rtificate of Death	d Mental Hyg	iene g, No. 2 (008 23102
- 57	93		Decedent's Name (First, Middle, Last)	Timodio or Bodi	2. Date of Deat	h	3. Time of Death
	Physicia		Margaret Jeanne Smith		Month July	Day	Year 2008 12:15 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Do		4c. County	
*	LAGIIIII		33 Raven Court	Elkton		Cec	· 1 1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 h			Birthplace (State or Foreign Country)
	Director		217-20-0140 1 M 2XXF 82 Yrs.	Months Days Hours M	July 14	1925	Norwood, Ohio
Т	Б .		Usual Residence of Decedent 10c. City, Town or L 10a, State 10b. County 10c. City, Town or L				10d. Inside City Limits
	aryla shov	<u> </u>					1 □ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	he M 8a-f otifle	Director	Maryland Cecil Elkto				
	a or a	ă	10e. Street and Number	10f. Zip Code	1		What Country?
	sath is 23	era	33 Raven Court 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Dependent of Hispania Origin	(Specify Vos or No		States ce - American Indian,
_	ter d	Funeral	1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒ Xho	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pr	uerto Rican, etc.)		ck, White, etc.
0030	urs af	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specif	w: White
5	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dec	dent's Usual Occupation		16b. Kind of B	usiness/Industry
7	e. an "r Med	ple		e kind of work done during most of DO NOT use retired)	working		
7	er the	Son	12 Sa	les Clerk		Reta	
and	tal Hy	Be (17. Father's Name (<i>First, Middle, Last</i>)		Name (First, Middle, I	flaiden Surnar	me)
<u>X</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	P	Ernest Joseph Southerington	Marie	0'Neil1		
Mar	2 short and is m			ing Address (Street and Number of			
≤ ^`~	1 and 2 Health em 27			Fortuna Way, Sal			
5	Pages 1 and 2 should nent of Health and Men nt: If Item 27 is marke iry or other traumatic		LA Bunal 2 (1) Cremation 3 (1) Hemoval from State	osition (Name of matory or other place)			- City or Town, State
altimol	t. Pa tmen tant: njury			Cemetery [Ju]	Ly 5,2008 I	Baltimo	re, Maryland
<u>a</u>	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other			2. Name and Address of Facility			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	27 South Main St			Approximate
			shock, or heart failure. List only one cause on each line.	ner the mode of dying, such as car	unac or respiratory arm	531,	Interval Between Onset and Death
ļ	Physician /Medical		disease or condition resulting in death) a. a.	of Cec	un	×	UNKnown
R-	Examiner		Due to (or as a consequence of):	Cancon			
	3	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
5	exec in and ial-tra	Exa	resulting in death) Last Due to (or as a consequence of):				
0/0 0/0	death certificate be executed e attending physician and of for use as the burial-transit	dical	d	<u> </u>			
Ò	rtifica ng ph as th	Ned	IE ESMALE.				
X Q Q	th ce tendii r use	an/	IF FEMALE: 23b. Was decedent pregnant is the part 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy			ate of delivery
	w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		M	onth Day Year
Ţ.	at the	Phy	9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the	and of the party of the Book I	OOo Did tol		tribute to the cause of death?
Ś	requires that een signed b nould be deta	ρ	Fait it. Other significant conditions contributing to death but not resulting in the	indenying cause given in Part i.	1 □ Y		3 Probably 4 Munknown
cords	requi	eted					3 FIODADIY 4 HOTIKITOWIT
ê	e law has b	Completed			— 24a. Was a	y	Were autopsy findings available prior to completion of cause of
	r: Th	Ö			perform 1□ Yes	2 No	death? 1 ☐ Yes 2 ☐ No
Z	slciar certif	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other:	Death (Check only on		
0	Attending Physician: r death. ector: After this certifici	<u>۲</u>	1 ☐ Yes 2 No		ng Home 5 Reside		
	ding After fune	ion	1 Natural 5 □ Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	20d. Describe in	ow injury occur	ned
UNISION	Atten deat ctor: y the	fica	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, s		28f. Location (S	reet and Num	ber or Rural Route Number,
2	after after Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town	n, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	S C	29a. Certifier 15 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and p	olace, and due to the c	ause(s) and m	nanner as stated.
	ne Ho 1 24 h ne Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death	occurred at the time, o	late and place	, and due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date sign	d (Month, Day, Year)
)				= 100569	147	7/	(10)
			30 Name and address of person who completed cause of death (Item 23a) (Type	, Print) // /a 0 / -	11	200 /4	16/ 1.22
	7		Claria DimonsorMD III 6	1. High Dt	Jule 5	12 6	16tan MO21921
	Sta		31. Date filed (Month, Day, Year) JUL 0 3 2008 32. Registrar's Signature	lank .			
	Registr	ar	JUL U U ZUUO DENNE AT	The same of the sa			

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Physician	
/Medical	
Examiner	

Funeral Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 72 hours after death with Je filed wit.

*I Hygiene.

*r than "r permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygie Important: If item 27 Is marked other t any injury or other traumatic event, <u>th</u>

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

burial-tran physician this To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A

that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be Certification: To filled in by Medical completely

1. Decedent's Name (First, Middle, Last) Straw Catherine 4a. Facility Name (If not institution, give street and number) Morningside House 7. Age (In yrs. last birthday, Social Security Number 1 □ M 2 🗙 F 577-18-9518 Usual Residence of Decedent 10a. State Director MD Charles 10e. Street and Number 70 Village Street ML2 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 3 No If Yes, Give Year or Dates: 1 Never Married 2 Married þ 3XXVidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Be Thomas Jefferson Coulby ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) Raymond E. Pierce/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses

2. Date of Death July 1^{Day} 2008 11:05A 4b. City, Town, or Location of Death 4c. County of Death Charles Waldorf Hours Min. 8. Date of Birth (Month, Day, Year)

Aug. 17, 1914 9. Birthplace (State or Foreign Country) Maryland Days Months 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🏋 No Waldorf 10g. Citizen of What Country? 10f. Zip Code 20602 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🎛 No Specify. Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Homemaker At Home 18. Mother's Name (First, Middle, Maiden Surname) Catherine Ferrall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Metropolitan Cr. 12, 2008 Alexandria, VA 22. Name and Address of Facility Raymond Funl, Service, P.A.

19326 Wilmott Dr. Benedict, MD 20612

July^{Date}

į	form 10	M006415635 Washington Ave., La Plata,	MD'2064
	23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line.	Approximate Interval Between
ĺ	Immediate Cause (Final disease or condition resulting in death)	a. Bilateral Pulmanay Emboli	Onset and Death
l	resulting in death)	Due to (or as a consequence of):	
Sequentially list conditions		6. Mobitz type II Heart block	Years
if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	()	
	Cause (Disease or injury that initiated events	a Hypertension	Heirs
	resulting in death) Last	Due to (or as a consequence of):	
		d. Hypotension	weekes
Ì			
i	#F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy	livery
I	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Day Year

9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diserse Sfinal

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

20c. Location - City or Town, State

	24a. Was an autopsy performed? 1∐ Yes 2 ☐ No	24b. Were autopsy findings availab prior to completion of cause o death? 1 ☐ Yes 2 ☐ No
((Check only one)	

7/11/08

25	. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No		26. Place of Death (Check only one)					
			Hospital: 1 ☐ Inpatient 2	2 ER/Outpatient	3 🔲 I	OOA Other: 4 Nursing F	Home 5 ☐ Residence	6 □Other (Specify)
	2 Accident	5 Pending investigation 6 Could not be determined		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred
			1 28e. Place of injury - A	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street at City or Town, State	nd Number or Rural Route Number, e)
29	a Certifier	To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated						

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.					
29b. Signature an	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)		

W

12070 old Line center Suterior would art MO 20602

30. Name and address of person who completed cause of death (Item 2\$a) (Type, Print) JL MD

31. Date filed (Month, Day, Year) State JUL 17 2008 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Patricia Cleo Timbrook 2008 July 6:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 5456 Wellspring Court Charles La Plata If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 X F 232-48-2085 75 Dec. 25, 1932 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No Directo Maryland Charles La Plata 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5456 Wellspring Court 20646 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White à 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Dental Hygienist Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ William Judy Catherine Kasmier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Timbrook/ Daughter <u>5456 Wellspring Ct, La Plata, Maryland, 20646</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Arlington Natl. Cem. July 21, 2008 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee #### MOI 45 23a. Part . Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, Maryland 20601 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a of Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No P 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed burial-trar and P.O. Box 68760. attending physician for use as the buria signed by the a d be detached f or Vital Records, page 2 s certificate

Division or Attending

death.

director, this After thi Certification: after death.

Director: / To the Hospital o within 24 hours aft To the Funeral Di completely filled in

Funeral

Director

28a-f show notified at

23a or must be

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

5 Pending investigation

6 Could not be 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

Medical

State

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title

29c. License number

29d. Date signed (Month, Day, Year)

. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12070 Old Line Ctr #302 Waldorf Leatherwood

istrar's Signatu**r**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b per FH 881 7/17/08 dk State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9:20 A /Medical WILLIAM COX TREAKLE 13 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u> Upper Chesapeake Medical Center</u> Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 □ F Director 217-18-6399 87 Dec. 8, 1920 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show be notified 1 ☐Yes 2 No Director Harford Street MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a edical Examiner must b 2642 Dublin Road USA 21154 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Mones. College (1-4or 5+) Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Edgar Treakle Grace Cox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne M. Treakle/Wife 2642 Dublin Road, Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7/17/2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 MOther (Specify)Entombment Bel Air Mem.Gardens 7/18/2008 Bel Air, MD 22. Name and Address of Facility 21. Signatury of Funeral Service License Harkins Funeral Home, Inc., Delta, PA 17314 part I. Ease fine disease or complications that caused the shock, or heart failure. List only one cause on each line, his that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) avieta Intracranial **Physician** /Medical Due to (or as a consequence of): Examiner Caqueritially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2D No 1 Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Edge wood MD # 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** Hilda Taylor 2 2008 /Medical 4c. County of Death 4b. Cify, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomi 9. Birthplace (State or Foreign HO 5 the 8. Date of Birth (Month, Day, Year 1/28/1929 7. Age (In yrs. last birthday) Social Security Number Hours Days **Funeral** Months 1 M 2 F North Carolina 79 242-42-3331 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10b. County 10a. State 28a-f show 1 ☐ Yes 2 XNo Wicomico Salisbury Examiner must be notified Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or USA 21804 30816 Dagsboro Road items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No white Baltimore, Maryland 21215-0036 "natural", or þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) DP & L Power Company clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be I and 2 should be fill lealth and Mental P Rachel Abbott is marked Jesse Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 30816 Dagsboro Rd., Salisbury, MD 21804 Robert L. Taylor/husband Health sem 27 i permit. Pages 1 and Department of Health Important: If item 27 any injury or other 1 once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 7/1/08 Salisbury, MD 4 □ Donation 5 □ Other (Specify) Parsons Cemetery Polloway ess of Facility Funeral Home Professional Association 21. Signature of Funeral Service Lig Herto 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequance of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequincia of) Examiner law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760. nding physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery nse 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Vear atter in the past 12 from for nonths? 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. been signed by the s 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 3 Probably 4 □Unknown 1 Tes 217 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy certificate has birector, page 2 s perform 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 1 Tyes P this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of funeral 27. Manner of Death Date of Injury Certification: After (Month, Day Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death TTo the Funeral Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number who completed cause of death (Item 23a) (Type, Print) Name and address of person vid sucell ast 32. Registrar's Signatur 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) ng Day 2008 6:00 am^M July Unkle Ann Patricia 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) St. Mary's Piney Point
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 17337 Goddard's Lane 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5 Social Security Number Min. Days Hours Maryland 10/30/1937 1 M 2 K F 70 214-36-3553 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10h County 10a. State 1 ☐Yes 2 No Piney Point Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20674 17337 Goddard's Lane 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1∐Yes 2M∑No Specify Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Communications Switchboard Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby M. Thompson Joseph B. Goddard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12371 Christy Lane, Los Alamitos, CA Robin White/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. George's
Episcopal Cemetery Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/12/2008 | Valley Lee, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22955 Hollywood Road, Leonardtown, MD M01521Shawn Aylesworth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Month pepatounal Immediate Cause (Final disease or condition resulting in death) months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last years Due to (or as a consequence 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Day 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 2 No 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an poalbuminenu autopsy 2 🗆 No 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending mber.

Examiner the death certificate be executed and use as the burial-trar physician atter for u signed by the a d be detached for o ۵. Division of Vital Records, page 2 s after death.

Director: After this certific
I in by the funeral director. or Attending filled in by 24 hours a Hospital

Physician

/Medical

Examiner

Funeral

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28a-f show

Director

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Completed

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Physician/Medical

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Completed

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Certification: To

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ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

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is marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked oth any injury or other traumatic event.

Physician

/Medical

filed within 72 hours after

Baltimore, Maryland 21215-0036

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Nu City or Town, State)
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29a. Certifier

29c License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23348 Nicholson Street, Holywood Md Olleen Denise Side

Registra

31. Date filed (Month, Day, Year)

32. Registrar's Signature

within 24 hou To the Fune completely fi

DHMH 17 Rev 1/2001

Maryland

Baltimore,

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	th with the 23a or 28 ust be not	al Direc	10e. Street and Number 8191 Dechado Po	INT RD.		10f. Zip Code	122	1	Og. Citizen of What Co	ountry?
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760,	be executed sician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.	Peno	l Cel	1 6	mæs		
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Vital	Physician: this certific ral director,	To Be	25. Was case reterred to medical examiner? 1 Yes 2 No	Hospital:	☐ ER/Outpatier	t 3 DOA Ot	26. Place of D	Home 5 Resid	ence 6 Other (Spe	ecify)
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	To th To th comp	M	29b. Signature and title of certifier	an-M.D		29c. Licen	150 number	-	29d. Date signed (Mon	ith, Day, Year) 2008
			30. Name and address of person who	completed cause of death (Ite	em 23a) (Type,	Print) (15) fal	m. Gl	on Bur	wig MD	21061
	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 7	hysicien: To the best of my kiminer: On the basis of examinar and manner stated. One of the basis of examinar and manner stated. One of the basis of examinar and manner stated.	nature	nok				

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State of Maryland / Department of Health and Mental Hygiene

and Sham Aisi		State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No. 2008 231												
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poured		Upper Chesapeake Medical Center Bel Air Harford												
Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 A												
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Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Memal H Important: If item 27 is marked of injury or other traumatic event, the		21 Signifiture of Funeral Service Uc. see 22. Name and Address of Facility William C. Brown Comm. F.HHarford P.A.												
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ViSic or Atte ther dez birecto	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City of Town, State)	y											
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed, within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)												
_		30. Name and address of person who completed cause of death (Item 23a)	_											
3		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	_											
Regist	rar	JUL 10 2000 MARKE XI SPARKE												

DIVISION OF VIIA DECOLUS, F.O. DOA 00/ 00,	F	Dallinore, Maryland 21
the Hospital or Attending Physicien: The law requires that the death certificate be executed	Ph / Ex	permit. Pages 1 end 2 should be filed wil
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mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cia lic	eny injury or other traumatic event, In
	É	

		epartment of Health and N Dertificate of Death	Mental Hygie		3111							
hysician	1. Decedent's Name (First, Middle, Last) Christopher Steven Abshire		2 Date of Death	Day Year	me of Death							
Medical xaminer	4a. Facility Name (If not institution, give street and number) 29 New Windsor Road	4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll								
neral ector	217 17 1720 12	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You April 8, 1	9. Birthplace (S Country) Rhode I	-							
fled at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD Carroll	or Location Westminster			ide City Limits							
at be notified ai Director	10e. Street and Number 29 New Windsor Road	10f. Zip Code 21157		Citizen of What Country?								
any injury or other traumatic event, the Medical Exercitret result be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married Married 3 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sr. If Yes, specify Cuban, Mexican, Puerto □ Yes 2 X No Specify:	pecify Yes or No- Rican, etc.)	14. Race - American Indi Black, White, etc. Specify: White	an,							
t, the Mudical I	(Specify only highest grade completed) (Decedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired) Graphic Designer	king 16	b. Kind of Business/Industry Graphic Desi	gn							
To Be C	17. Father's Name (First, Middle, Last) Steven Abshire		ne (First, Middle, Ma ca Miller	iden Surname)								
er traum		Mailing Address (Street and Number or Ru New Windsor Road, V										
ury or otn	1 Burial 2 Cremation 3 Removal from State	crematory or other place) unty Cremation 07/18	8/2008 Sy	c.Location - City or Town, St vkesville, MD								
eny in	21. Signature of Funeral Service Licensee 22. Name and Address of Facility flaight Funeral Home & Chapel P.O. Box 195, Sykesville, MD 21784 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate											
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lan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day	Year							
হি	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.		cco use contribute to the caus								
Completed			24a. Was an autopsy performer 1 Yes 2	24b. Were autopsy find prior to completion death?								
To Be	25. Was case referred to medical examiner? 1 Yes 2 No	atient 3 DOA Other: 4 Nursing He	th (Check only one) ome 5. Residence	ce 6 Other (Specify)								
Certification:	2 Accident investigation 3 Suicide 6 Could not be	ury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how									
	28e. Place of Injury - At home, farm building, etc. (Specify) 29a. Certifier 12 Certifying Physician: To the best of my knowledge,		City or Town, S		r Number,							
redical	(Check only 2 Medical Examiner: On the basis of examination and one) and manner stated.	or investigation, in my opinion, death occur	red at the time, date	and place, and due to the ca								
¥ Co	29b. Signature and title of one Minimum Minimu	29c. License number 29d. Date signed (Month, Day, Year 7/17/08										
State	30. Name and address of person who completed cause of death (Item 23a) (TAMIR FATHI M.D. 600 N. WOLFE S 31. Date filed (Month, Day, Year) 32. Argistrar's Signature	st, BALTIMORE, MI) 3198C)								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Day Year ELEANOR M. AUT JULY 2008 8:30PM 15 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **FUTURE CARE** Baltimore City Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 28, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1 □ M 2 🛣 F Maryland 213-01-6649 91 Yrs. **Director** Usual Residence of Decedent death with the Maryland 10a. State 10h. County ns 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Marvland Baltimore City Baltimore City Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 S. Elwood Avenue 21224 USA Funeral Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or items any Injury or other traumatic event, the model Eventual and once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: ₫ 3℃Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Retail Industry Retail Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Cork Agnes Zellor ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1718 Mount Carmel Rd. Parkton, Md. 21120 F. Edward Goetz (Grandson) Pages 1 a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Parkwood Cemetery 7-18-2008 Baltimore, Md. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Ligensee Lassahn Funera. 7401 Belair Rd. Home €.3. Lassahn Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclastic Corman Operator Disease **Physician** Hyper terior disease or condition resulting in death) 40001 /Medical o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Tyes 2 →No 9 Unknown ģ signed I Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown page 2 should Completed Decerta 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has 24a. Was an 25. Was ase referred to medical 1 ☐ Yes 2 -NO : After this certifical funeral director, I Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 1No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

Division of Vital Records, P.O. Box 68760 n 24 hours after death.

e Funeral Director: A letely filled in by the fu completely within 2

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certified

Milliagel

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7310

Registrar's Signature

Cidead Ruwarts of

Year) 1 8 2008 D19667

Ztelies Hymony & 508 Gleu Bornie, Maryland 2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month ragass **Physician** 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F 78 Saudi Director N/A Arabia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f sho Examiner must be notified at 1 ☐ Yes 2 👿 No Riyadh City Director Saudi Arabia N/A 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number P.O. Box 340572

Page 12. Was Decedent Ever in U.S. Armed Forces? Saudi Arabia "natural", or items 23a 11333 Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2x XNo Specify: Specify: à 3 Widowed 4 Divorced Arbic Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4 or 5+) various Business Man 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fasla Alragass Faihan _M. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kingdom Saudi Arabia Satam Alragras-brother P.O. Box 340572 Riyadh City Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Saudi Arabia 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Riyadh City 7/21/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Avenue Baltimore, MD 21202 Approximate Interval Between Onset and Death
5 minutes Immediate Cause (Final disease or condition resulting in death) Cardiac Physician /Medical 2 years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the ucau comment within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and a few sites of the funeral director, page 2 should be detached for use as the burial-transit. resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📝 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 🗌 No 1 Tyes **Division of Vital** 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
1 ☐ Yes 2 ☑ No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28c. Injury at 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day, Year) 2008

32 Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

of death (Item 23a) (Type, Print)

08-05311 Floyd Banks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23114

		- For State Registrar		-		Certific	cate of	Death					Reg. No.	644	00		
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ledical Examii		Floyd Ban	ks_									July 11, 2	8008	0	(Death	0036	1115
		4a. Facility Name (if not inst			umber)		4	b. City, Tov Baltimo		cation of	Death	,	46.	County of	Deau		
		2525 Eutaw Place			- "					If Under	2445	8. Date of Bi	irth/AANA/D	D/YYYY	9 Rinh	nplace (Sta	ate or
Funeral		5. Social Security Number	6. Se			n yrs. last b	oirthday)	If Under	Days	Hours	Min.				Foreign	ntry) M	1
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21215-0036 uld be filed within 72 hot Mental Hygiene. marked other than "nat ic event, the Medical Exa	å	Warren A.					401-14-11	A J.J	F	lor	enc	e P. ural Route Nu	Gree	n Town	n State	Zin Code	
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timent rtant:	- 1	4 Donation 5 Other Specify: Cheasapeake Crem. 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA									<u> </u>			_			
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Box e death c the atten ed for us	Physician	1 Yes 2 No 9	Unknow	. '=	nown		3 <u> </u>	Hei (Opoo								_	
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Division tal or Attendii rs after death.	Certification:	3 Suicide 6	Could not	be 28e. Pla	ace of Injur	ry - At home	e, farm, stre	et, factory,	office bu	uilding, et	c.	28f. Location or Town		and Numb	er or Ru	ural Route	Number, City
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Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u	Medical	29b. Signature and title of		and manne	stated.					e number						onth, Day,	
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DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2008 5:42 PM /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner MD TIMORE niver Maryland If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 22, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Sex **Funeral** Months Davs 1 □ M 2 🖺 F Virginia 83 229-22-9399 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County show If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Engineer must be notified at 1 ☐ Yes 2√ No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 719 Maiden Choice Lane BRT31 21228 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2¶No Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 should be filed w h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Frank Dixon Lillian Vann Query 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 nt of Health a University of Maryland Med Ctr 22 S. Green Street Baltimore, MD 21201 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens
Ar, thony D Pleasant State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 towsan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician medias OdALS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trans Due to (or as a consequence of) Box 68760, physician pe Physician/Medical CERTIFICATION APPROVED BY MEDICAL EXAM the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont ò Day Year 5 Other (specify) P.O. 1 Tyes 2 DING the 9 Unknown 9 Unknown ģ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Ves 2 \(\textstyle{\textstyle{1}}\) No has e 2 s page certificate 1 □Yes of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division Injury 1 Natural 5 Pending investigation within 24 hours and voc... To the Funeral Director: Aft 9:00 AM 1 ☐ Yes 2 ☐ No Operative Complication 28f. Location (Street and Number or Rural Route Number, Gity or Town, State) 2 Decident une 27,2008 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide nospital Da I hmore 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day,

Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** July 8, 2008 8:58 AM M Frank Butta /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) unk 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 83 Director Jan 8, 1925 212-72-9353 Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Its Medical Examinar must be notified at Director MD 1 ☐ Yes 2 ☐ No Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 2 and injury or other traumatic event, the Medical Examination between the Medical Examination once. 6530 Democracy Blvd 20817 USA 12. Was Decedent Ever in U.S. Unk Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: ģ Specify: white 34 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suburban Hospital 8600 Old Georgetown Road Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5፟型Other (Specify) in state 21. Signature of Europe Service Bossey leasant State Anatomy Board 655 W. Baltimore Street LUTTON Baltimore, MD san 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ischemic cardiomyonathy DIKHOWY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 moleusion. 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 No Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

an

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Soberban

Park

18

2008

31. Date filed (Month, Day, Year)

D0060117

7/4/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death North West Hospital Center Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 10,1933 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💆 F Months Days Hours Min 172-28-8878 75 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County in than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 103 Center Place Apt 322 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 9 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medge. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Susan Ondusko Anthony Brozosky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Center Place Apt 322, Dundalk, MAryland 21222 Charles G. Baratone Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest VA. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation July 22, 2008 3 Removal from State Owings Mills, MD 4 Donation Signature of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. P. 11 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, storal, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as the IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ned by the atter s detached for u 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) Year P.0. 9 Unknown 9 Unknow signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2) X No Other: 4 \sum Nursing Home 5 \subseteq Residence 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) TUSP Z After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. within 2 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar

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State

31. Date filed

(Month, Day, Year)
JUL 1.8 2008

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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والروة	Physic		1. Decedent's Name (First, Middle,Last)					2. Date of Deal		3. Time of Death	
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			Facility Name (if not institution, give street and number) Franklin Square Hospital			city, Town, or L osedale	ocation o	f Death	4c. County of Dea Baltimore Co		
	Funeral			(In yrs. last bir		Under 1 Year	If Under	r 24Hrs 8 Date of Bir	th (MM/DD/YYYY) 9. B		
	Director		002-68-7422 1XM 2 F	37		nonths Days	Hours	Min	Fore	ign	
		-	Usual Residence of Decedent		Yrs.			November	26,1970	ountry) NH	
	any			10c. City, Towr	or Location					10d. Inside City Limits	
	* .	=	Maryland Baltimore	Mi	ddle R	ver			•	1 Yes 2 X No	
	Maryland 28a-f show	Director	10e. Street and Number			f. Zip Code		11	0g. Citizen of What Co	untry?	
	the N a or	اغً	705 Macdill Road			212	20		USA		
	ms 23	Funeral	11. Marital Status 12. Was Decedent E	ver in U.S.	13. Was De	cedent of Hispa	anic Origi	in? (Specify Yes or No		rican Indian, Black,	
	r deatl or ite must	Ē	1 Never Married 2 Married Armed Forces? 1 Yes 2X	No				Puerto Rican, etc.)	White, etc.		
	s after ral",	by	3 VVIdowed 4 Divorced in 1es, Give rear			2 X No			Specify: Wh	ite	
	hour natu	Completed	15. Decedent's Education (Specify only highest grade comp			sual Occupation f working life. I		ind of work done use retired)	16b. Kind of Business/Industry		
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= 8	5-0036 lled within 7 Hygiene. l other than	ĕ	12 years 17. Father's Name (First, Middle, Last)		Sa.		Mother's	s Name (First, Middle, M	Goodyear		
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- 7	21 ould bould bend I Men	10	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Ad	ress (Street	and Numb	ber or Rural Route Num	iber, City or Town, Stat	e, Zip Code)	
	ore, MID 21215-0036 set and 2 should be filed within 72 hours after death with the Maryland set Land 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Without 7 is marked other than "natural", or items 23a or 28a-f sho her traumatic event, the Medical Examiner must be notified. It once,		Kimberly Baron wife						er, MArylan		
	re, slan fHeal fiten		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State	20b. Place		(Name of ceme		Date	20c. Location - City o		
	Page: Page: nent o ant: l		4 Donation 5 Other Specify:	Bayvie	ew Crer	atory		July 18, 2008	Baltimore	City,MD.	
3	BAILIMOTE, MID 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	1	21 Signature of Funeral Service Licensee		22 Name	and Address of	f Facility		Dundalk,P.		
			Contions Connelle	8	1 / 110	Sorrei	rs Po	oint koad.	Dungalk.Mg	. 21222	
	Physician Medical		23a. Part I. Enter the dipease, or complications that caused I failure. List only one bause on each line.	ie death. Do n	ot enter the m	ode of dying, su	uch as ca	rdiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and	
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		je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	juence of):			_				
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0	ansit ansit		events resulting in death) Last Due to (or as a conseq	uence or);							
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76.0	rou, icate be ex physician the burial	Med	IF FEMALE: 23c. If yes, outcome	of pregnancy					23d. Date of delive	TV	
703	h certific tending puse as the		23b. Was decedent pregnant in the past 12 months?	2	Fetal d	eath 3	Ectopic	pregnancy	Month	Day Year	
3	box oo	Physician	1 Yes 2 No 9 Unknown 9 Unknown	me of death	5 Other	(Specify)					
0	by the	된	Part II. Other significant conditions contributing to death I	but not resultin	a in the under	lving cause giv	en in Par	t I. 23e, Did to	bacco use contribute to	the cause of death?	
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Č	e law e has l	ם						autops		completion of cause of	
ă	cian: The l certificate l ector, page		25. Was case referred to medical			00 00	5 D 11- 72	1 Yes	2 No 1 Y	es 2 No	
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	- # . ^ 4	흴	Natural 5 Pending 7/14/08		26 hrs	1 Ye:	s 2 X	could no	ot be deter	cmined	
Divieion	or Att	ertification	2 Accident Investigation 7/14/00 3 Suicide 6 X Could not be 28e. Place of Inju				lding, etc.	28f. Location (S	treet and Number or R	ural Route Number, City	
Ë	ospital or A hours after meral Dire y filled in b	Cert	4 Homicide determined (Specify) res	idence				or Town, St MIddle	ate)/05 MacD: River, MD	ill Rd.	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my l	knowledge, dea	ath occurred a	t the time, date	and plac	e, and due to the cause	e(s) and manner as sta	ted.	
	To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated.	nation and/or i	nvestigation, i			urred at the time, date a			
		2	29b. Signature and title of certifier		,	29c. License r			29d. Date signed (Mo	onth, Day, Year)	
			mun /	(O.C.M.	.E.		July 15, 2008		
	0		 Name and address of person who completed cause of dea Zabiullah Ali, M.D. Assistant Medical Exa 	,	11 Donn C	reet, Baltim	oro M	D 21201			
	9	ato	31. Date filed (Month, Day, Year) 32. Registrar's		i i reilli S	reet, balum	iore, M	U Z IZVI			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 16, **Physician** John F. Burke 2008 10:10 am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day Year 7 01/28/1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 130-16-7958 1 X M 2 □ F 81 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Introprent: If Item 27 is merked other than "naturel", or Items 23a or 28a-f show any Injury or other treumatic event, the Medical Examinar must be notified at outs. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Howard Clarksville Director 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21029 USA Ramsgate Court 7116 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1. ☑Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1944-1946 Specify: Specify. 3 Nidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Electrical Engineer 5+ 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis William Burke Margaret M. O'Keeffe 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7116 Ramsgate Court, Clarksville, MD 21029 Bratchie / Daughter Pat 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition IX Burial 2 ☐ Cremation 3 X Removal from State Calverton National Cemetery 7/22/2008 Calverton, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Avenue, Baltimore, MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical phys. the b IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ormed? 2 **X**No 2 🗆 No 1 ☐ Yes 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔣 No 1 Inpatient 2XXER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident s after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 17, 2008 D0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Ave, 1 #1-17, 1 Silver Spring, 1 MD 20902 Sunitha Bhogavilli, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 1 8 2008 Registrar

DHMH 17 Rev 1/2001

			1 - State of Maryland / State of Maryland /		t of Health a e of Death	nd Mental H	ygiene Reg. No. 200	8 22121			
-	Physic /Med	ical	1. Decedent's Name (First, Middle, Last) Louise C. Blalock			2. Date of I Month July	13, 2008				
P	Exami	ner	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital		Town, or Location of Linton	Death	4c. County of Dea				
1	Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last.			Min. (Month,	Birth 9. Bir	thplace (State or Foreign			
	with the Maryland a or 28a-f show t be notified at	ctor	10a. State 10b. County 10c. City, To	own or Location itland				10d. Inside City Limits 1 X Yes 2 □ No			
	with the a or 28 be no	Dire	10e. Street and Number	10f. Zip			10g. Citizen of What Co	ountry?			
920	er death items 23 ner musi	by Funeral Director	3023 Sunset Lane 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No ff Yes, Give			in? (Specify Yes or I Puerto Rican, etc.)	USA No- 14. Race - Ame Black, Whit Specify: B]	te, etc.			
Baltimore, Maryland 21215-0036		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		k done during most e retired)	of working	16b. Kind of Business	ŕ			
nd 21		Be Col	10th 17. Father's Name (First, Middle, Last)	Catere		's Name (First, Midd	Self Empl le, Maiden Surname)	.oyed			
ıryla		2	Gordon Hamlett 19a. Informant's Name/Relationship (Type. Print) 11	9h Mailing Address	Lal.		ison nber, City or Town, State, 2	Zin Code)			
, Ma	and 2 sealth ar			3023 Suns				0746			
nore	ages 1 ent of H t: If iter y or oth		123 Bullati 2 Dolettiation 3 Differnoval from State	of Disposition (Nam tery, crematory or ot	1	Date	20c. Location - City or				
Baltir	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) Fort 21. Signature of Funeral Service License	22. Name and 3821 1	d Address of Facility	Austin 1	<pre>8 Brentwoo ROyster Full ashington,</pre>	neral Home			
	Physician		23a. Part1. Enter the sease, or complications that caused the death. Do shock, or he ailure. List only one cause on each line. Immediate Cause (Final disease or condition	o not enter the mode				Approximate Interval Between Onset and Death			
7	/Medical Examiner	П	resulting in death) Due to (or as a consequence								
€.	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liberase or injury that initiated events	e of):	,						
8760,	icate be executed physician and the burial-transit	dical	resulting in death) Last Due to (or as a consequence d	e of):							
P.O. Box 6	w requires that the death certific: been signed by the attending pl should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 moviths? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown				23d. Date of del Month	ivery Day Year			
	quires that in signed t uld be det	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying ca	use given in Part I.		tobacco use contribute to	the cause of death?			
Division or Vital Records,	The lar ate has page 2	Completed				24a. Wa aut per 1 Yes	opsy prior to o	topsy findings available completion of cause of			
VII	Physiclan: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 □ DOA	Othor	f Death (Check only					
ion or	ding Ph I. After th funeral		27. Manus of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	<u> </u>	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	sidence 6 Other (Spece how injury occurred	ify)			
Divis	声육등	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)			City or To	(Street and Number or Ru own, State)				
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Meyrical Examiner: On the basis of examination a and manner stated.	ge, death occurred a and/or investigation,	at the time, date and in my opinion, death	place, and due to the occurred at the time	e cause(s) and manner as e, date and place, and due	stated. to the cause(s)			
	To the within complete complet	Me	29b. Signature and title of conting ()		License number)	29d. Date signed (Montl	n, Day, Year)			
ó	Ź '	-	30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	E Sunto	310 Wash	ing ton Oc 2	2023			
9	Sta Registr	te ar	31. Date filed (Month, Day, Year) JUL 1.8 2008 32. Registrar's Spriature	parte	40010		7	to de-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and N 1 - State Registrar Certificate of Death		ene g. No. 2008	23121
			Decedent's Name (First, Middle, Last)	2. Date of Death	1	3. Time of Death
	Physici /Medio		Mary Corbin	Month	8 ams	02:00 AM
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
1			Prince George's Medical Center Cheverly		Prince	George's
	Funera!		5. Social Security Number 6. Sex 1 M 2 F F 80 Yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, July 19,	Year) 9. Birthp	lace (State or Foreign try) unk
	Director		230-28-4008 1 M 2X F 80 Yrs. Solution Solut	July 19,	, 1927	
	/land		10a. State 10b. County 10c. City, Town or Location		10	0d. Inside City Limits
	Mar.	향	MD Prince George's Hyattsville			1 ☐ Yes 2 ☐ No
	or 28)ire	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Coun	try?
	death with the Maryland rms 23a or 28a-f show	ā	5806 Arbor Street 20781		USA	
	er de	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	
36	rs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ No If Yes, Give 1 □ Yes 2 ሺ No Specify: 3 ሺ Widowed 4 □ Divorced Year or Dates:		Specify: W	hite
5-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	un 1	6b. Kind of Business/Inc	lustry unk
215	hin 7; e. an "n	Be	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing		
2121	ygien /gien er th	Completed	unk unk			
nd	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last) unk 18. Mother's Name	e (First, Middle, M	laiden Surname)	unk
<u>,</u>	d Men narke	은				
Maryland	nd 2 st alth and 27 is n r traur		19a. Informant's Name/Relationship (Type. Print) Prince George's Medical Center 19b. Mailing Address (Street and Number or Rur. 3001 Hospital Drive C			Code)
re,	is 1 au of Hea Item	1	cometeny crematory or other place)	Date 2	20c. Location - City or To	wn, State
mo	Page nent d int: If		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 🛣 Other (Specify) in State			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinar must be notified at once.		21. Signature of Funeral Service Limisee Pleasant 22. Name and Address of Facility State Anatomy Boar Baltimore, MD 212		Baltimore	Street
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		st,	Approximate Interval Between
- Lag	Physician	8 8	Immediate Cause (Final disease or condition resultion in (death)		A.	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			
	Examiner	ī	Sequentially list conditions, b. Sep 515			
	rec	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		Į.	
,	execu n and al-tra	Examine	that initiated events consequence of):			
8760,	cate be executed physician and the burial-transii	dical	d			
9	rtifical ng phy as th	fedi				
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delive	,
0.	the at	Physician/Me	in the past 12 months? 1		Month	Day Year
σ.	res that the de signed by the a be detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
Records,	signe d be o	Completed by	Acute renal failure		s 2□No 3□Prob	
200	w require been si should b	ete		24a. Was an	24h Were suto	psy findings available
Re	: The law cate has page 2 s	ш		autopsy	prior to coi	npletion of cause of
Vital	ician: Th certificate ector, pag		25. Was case referred to medical 26. Place of Death		No 1 ☐Yes	2 □ No
<u>></u>	ysician: is certific director,	o Be	examiner?		nce 6 ☐Other (Specifi	v)
υot	ding Phys h, After this funeral dii	T:U	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how		
ioi	endin sath, or: Af	atic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division	al or Attendii s after death. al Director: A ed in by the fu	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town,	eet and Number or Rura State)	I Route Number,
	pital o		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the co	(a) and manner as a	And d
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, da	ite and place, and due to	the cause(s)
	To th comp	Me	29b. Signature and tile officertifier 29c. License number	29	d. Date signed (Month,	Day, Year)
			mo D0229-9-0		118 2008	3
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	4.0	-00	_
	-01		31. Date filed (Month, Day, Year) 32. Registrar's Signature	MO	20783	
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Physician /Medical Examiner **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 271s marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Marties Iteminer must be notified at agnee. Name Known to Ansicians Counts, Florio To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 3 **Physician** /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Face	State of Ma	ıryland / De	partment of I	Health and N	∕lental Hygie⊦	ne	
For State Registrar			ertificate of		Reg.		2 2212
Decedent's Name (First, Middle, L.)	.ast)				2. Date of Death	2000	3. Fime of Death
FLOVD	Count	5			July 13	Day Year	6:15 PM
4a. Facility Name (It not institution, g			4b. City, Town,	or Location of Death		4c. County of Deat	th
YA Maryland HE 5. Social Security Number 6.	SITHCATE SU Sex. 7. Age	STEM (In yrs. last birthdo	Perry F	OIN'T	8. Date of Birth	Cecil 9. Birt	thplace (State or Foreig
213-44-3349 Usual Residence of Decedent	1 X M 2□ F	86 Yrs	Months Days	Hours Min.	(Month, Day, Ye 03-22-19	2 Z Co	SC Schintry)
10a. State 10b. County	114	10c. City, Town or)	more	,		10d. Inside City Limit
10e. Street and Number	fton.	Ave	10f. Zip Code	21217	10g.	Citizen of What Co	ountry?
11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Anned Forces? 1 1 Yes 2 □ N If Yes, Give Year or Dates:	1	 Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No 	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Race - Ame Black, White Specify:	
15. Decedent's I	Education	i (G	ecedent's Usual Occu	during most of work		. Kind of Business/	Industry
Elementary/Secondary (0-12)	College (1-4or 5-	·) Cla	e. DO NOT use retire	vestiga	ter	5SF	4
17. Father's Name (First, Middle, Las	st)			18. Mother's Name	e (First, Middle, Maid	den Surname)	
1-rank	Counts	<u> </u>		Hnn	e Ba	Tes	
19a. Informant's Name/Relationship	(Type. Print)	fe 21	ailing Address (Stree	t and Number or Rur	ral Route Number, Ci	ty or Town, State,	Zip Code)
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Place of Dis	sposition (Name of crematory or other pla	ace)	Date 20c	. Location - City or	Town, State
4 Qonation 5 ☐ Other (Spec	cify)	Crowns	Ville le	m. 107/a	21/06/	MOWNSVI	110, Me
21 Signa ure a Funeral Service Lic	ensee Awel	25/	22. Name and Addr	ess of Facility	h Rain	uneral o	1307
23a. Part 1. Enter the disease, or co	mplications that caused	the death. Do not	,	1 0	or respiratory arrest,	<u> </u>	Approximate Interval Between
shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on each lin	e.					Onset and Death
resulting in death)	Due to (or as a	a consequence of):					Chungon
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if any, leading to immediate	Due to (or as a	a consequence of):	-				
Cause (Disease or injury that initiated events resulting in death) Last	c. Diabetes	consequence of):	s Type Tw	0			
		2 consequence on.					
	d						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other <i>(specify)</i>	су		23d. Date of de Month	elivery Day Year
Part II. Other significant conditions	contributing to death bu	it not resulting in the	e underlying cause gi	ven in Part I.	23e. Did tobac	co use contribute to	o the cause of death?
Dementia					1 ☐ Yes	2 □ No 3 □ P	robably 4 📉 Unknow
					24a. Was an	24b. Were a	utopsy findings availab
					autopsy performed	? death?	completion of cause of s 2 □ No
25. Was case referred to medical				26. Place of Deat	th (Check only one)		
examiner? 1 ☐ Yes 2 ☑No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpa	tient 3 DOA Ot	her: 4 Nursing Ho	ome 5 Residence	e 6 ☐ Other (Spe	ecify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	ry 28b. Tim (, Year) Injur	y Wo	rk?	28d. Describe how i	njury occurred	
2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be]Yes 2□No			
4 Homicide determine	28e. Place of Inju- building, etc	ry - At home, farm, . (Specify)	street, factory, office		28f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
	Physician: To the best of aminer: On the basis of and manner sta	examination and/o					
29b. Signature and title of certifier	4	^	29c. Licen	se number	29d.	Date signed (Mon	th, Day, Year)
Shen s	* Has	themi.	MU D2	4648	07	1-13-	2008
Sher A. Hashmi.	o completed cause of de	eath (Item 23a) (Type 18 and 1		are System	, Perry Po	int. MD	21902
31. Date filed (Month, Day, Year)		r's Signature		-			
JUL 182	2008 J.	J. J.	9842				

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State

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dyr 9881 7-18-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23123 Reg. No 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 15 Day Physician 2008 19:05 Chapman Lee Samuel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours X□ M 2□ F Yrs. 32 09 NC **Director** 11 237-50-2200 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Marial Hygiene. Department of Health and Marial Hygiene. Innoctant: If item 21 is marked other than "natural", or litems 23a or 28a-f sho any injury or other traumatic event, I'm Madical Evan in an Ibor rothed at 1 □Yes 2 No Funeral Director Rockville MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20850 13528 Glen Mill Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1♥ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 21215-0036 1 □Yes 2 □No Specify Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)
3yrs+ Elementary/Secondary (0-12) U.S. Army 12th grade Chief Warrant Officer 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Callie Smith Ed Chapman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13528 Glen Mill Road, Rockville, Md 20850 Ann L. Chapman-Wife altimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 7/19/2008 Silver Spring, Md 1 ☐ Donation 5 ☐ Other (Specify) Gate's of Heaven 22. Name and Address of Facility ature of Funeral Service Licensee March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Pneumonia /Medical Due to (or as a consequence of): **Examiner** Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Be Completed by Metastatic Prostate Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an <u>Anemia</u> autopsy 1 ☐Yes 2 No 2 X No 1 Yes UTI funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier endre DO0 67593

Registrar DHMH 17 Rev 1/2001 Hedred center

20850

Rockvelle, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901

32. Registrar's Signature

Mubnew ~ 31. Date filed (Month, Day, Year)

Levelie, HD

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:05 A M JULY 10, 2008 ORVILLE CARR /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1**⊠** M 2□ F March 29, 1932 Maryland 219-28-7613 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2105 Funeral 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 Tryes 2 No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. δ 3 ☑ Widowed 4 ☐ Divorced white Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BGJE 12 50X 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Marion ပ္ eaque 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any Injury or other trau R 14 11, MD 2105 20c. Location - City or Town, State Hay Road Forest Donald 2252 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation memorial 4 □ Donation 5 □ Other (Specify) arden 21. Signature of Funeral Service Licenses 22. Name and Address of Facility al Chapel & Cremation Services Evanstuner 3 Newport Drive Forest Hill MD a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANCHE OUTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical the attending ph for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 donknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1☐ Yes 2 **N**6 Hospital or Attending Physician: after death.

Director: After this certific
I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 5 Pending investigation Injury (Month, Day Year) 1-PNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier

State Regis<u>trar</u>

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

BEL AIR, MD.

and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MACPHAIL ROAD

32. Registrar's Signature

ROBERT DUNCAN

1 8 2008

31. Date filed (Month, Day, Year)

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Physicia /Medio		1. Decedent's Name (First, Middle, Last William	, F Chew, []]	III				2. Date of Do Month 1 July 1	5 Day 5, 20	08	3. Time of Death 1:52 P M	
Examin Funeral Director		4a Facility Name (If not institution, give Kingston Park 5. Social Security Number 6. Second Security Number	street and number) FK Lane Lane	e (In yrs. las.	1	Middle	River If Under 24 Hrs Hours Min.				imore	
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Location						10d. Inside City Limits	
e Mary 3a-f sho	Director	Md. Balt	imore		Mi	ddle R	liver				1 □Yes 2 XNo	
th with the 23a or 28	al Dire	10e. Street and Number W. Kingston 78 kingston Par	Park Lane k Lane		10	f. Zip Code	21220 21221		10g. Citi:	zen of What Co USA	untry?	
Dalumore, Maryliand 21215-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Michal Evanture Coult to infile of an once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:			ecedent of I specify Cub s 2 🛛 No	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	14. Race - Am Black, Whi Specify:			
Baltimore, Maryliand 21215-0035 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hyghene. Important: If Item 27 is marked other than "natural", or any Injury or other traumatic event, itm Medial Evan. Dance.	Be Completed	15. Decedent's Edic (Specify only highest grad				f work done OT use retire	pation during most of word eal Estat			16b. Kind of Business/Industry Development		
e filed v al Hygid other vent, th	3e Cc	17. Father's Name (First, Middle, Last)	J1 1 1 1 1 1 1 1 1 1			<u> </u>	18. Mother's Name (First, Middle, Maiden S					
Tarylan 2 should be and Mental is marked of	မ	William F. Ch			Dorothe		<u> </u>	7:- O- d-)				
and 2 sh ealth and m 27 is n		ratiomar'sAireSoskaya Tanya Chew/Wife	CKeW/Wife	: . .7	78 W. K.	iress (Street Ingsto Ion Pa	n Park L n Park L FK Lanc	ane, Mic Middle	ld Le River	River, 2	Md ^{Code)} 2122 0	
more, Pages 1 a nent of He int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify		20b. Plac	ce of Disposition netery, crematory	(Name of or other pla	ce)	Date .7/08	20c. Lo	on, Mar	Town, State	
balti permit. Departm Importa any inju		21. Signature of Funeral Service Lio	1 1		22. Nan		ess of Facility Ru				Home, Inc.	
Physician /Medical Examiner	20 0	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on e ch lin a. Due to or as	dom	Do not enter the			c or respiratory			Approximate Interval Between Onset and Death	
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rdS, F. quires that t n signed by	by	Part II. Other significant conditions co	ntributing to death bu	ıt not resultir	ng in the underly	ing cause giv	ven in Part I.				o the cause of death?	
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	Certification: To	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day 28e. Place of Inju	i, Year)	Injury M		rk?]Yes 2 □ No				ural Route Number,	
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Hospital 24 hours 6 Funeral 1	Medical		rsician: To the best of iner: On the basis of and manner sta	examination								
To the within 2 To the Somplei	Me	29b. Signature and title of certifier	Λ			29c. Licens	se number		29d. Dat	e signed (Mont	h, Day, Year)	
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50'		30 Name and address of person who c	MP 6	569	N. Ola	rlas s	ST BA	Timo	n pe	DZ	1204	
Sta Registr		31. Date filed (Month, Day, Year)	8 Registra	ar's Signatur	aparer.	- St	/					

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71			1 - For State Registrar	State of Me	ai yiai k			ite of L		vicinairiy		2008	23120	6	
	Physicia	an	1. Decedent's Name (First, Middle	, Last)						2. Date of De	eath Da	ay Year	3. Time of Death		
	/Medic		William	Covington						July 1			8:45 A ^M	1	
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	or 28	Director	10e. Street and Number				10f. Z	Zip Code			10g. C	tizen of What Co	untry?		
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	tems	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		3. 13.	Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	0-	 Race - Ame Black, White 			
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פ	be filed ntal Hyg ed othel event,	Be C	17. Father's Name (First, Middle, I	Last)	•				18. Mother's Nan	ne (First, Middle	e, Maidei	n Surname)	, , , , , , , , , , , , , , , , , , , ,		
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Maryland	2 sho and I Is ma		19a. Informant's Name/Relationsh	nip (Type. Print)			Mailing Address (Street and Number or Rural Route Number, C								
	s 1 and 3 f Health Item 27 other tr		Mark E. Jacks	ceet,NW	·										
Baitimore,	ges 1 it of F if ite or ot		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Crematory 7/18									20c. Location - City or Town, State			
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Ra	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Fundamental Service		, DC 2001										
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0	Physical this call dire	၉	1 Yes 2 No			ER/Outpatie			4 Li Nursing F			6 ☐ Other (Spe	ecify)		
000	nding I ath. r: After e funer	ation:	27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident investig		y, Year)	28b. Time o Injury	M	28c. Injun Work 1 🗆	yat ?? Yes 2□No	28d. Describe	how inju	ary occurred			
DIVISION	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ury - At ho c. (Specify	me, farm, str	reet, facto	ory, office		28f. Location City or To	(Street a	and Number or Ri te)	ural Route Number,		
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	2		, ~ ,	who completed cause of d	eath (Item	23a) (Type,	Print)	1 5	60 lov	2090	3	3WD Ea	rt		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** CROMARTIE MARTHA SUL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street end number) **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** 1 M 2 XF 1928 80 MD 212-26-6846 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County show r than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified et 1¥ Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number Apt. Lanvale Street Funeral 1300 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filed within 72 hours after a and Mental Hygiene. is marked other than "natural", or Itel 1 Yes 2XXIo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/☐XNo Specify Specify: δ 3 ♥ Widowed 4 □ Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify onfy highest grade completed) Market Elementary/Secondary (0-12) 12th College (1-4 or 5+) cashier Stop Shop & Save 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 Samuel Johnson Jane Brown ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 924 Punjah Circle Middle River, MD 21221 Renee White-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or oth Bunal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cemetery 7/21/2008 Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST MD 21202 1101 E. North Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC BREAST CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, It any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of the burial-transit and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical certificate be as IF FEMALE: ase 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Tectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 Z No 9 Unknown P.O. 9 Unknown the been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be Other: 4 \subseteq Nursing Home 5 \subseteq Residence Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 1 Tes 2 No မ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury or Attending 1 Yes 2 No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, à 4 Homicide City or Town, State) Hospital 24 hours a Funerel D 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Vithin 2

State Registrar

in 31. Date filed (Month, Day, Year)

A.

29b. Signature and title of certifier

32. Registrar's Signature

- MEDICIAL DOCTOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For State Registrar	State o	of Maryland	d / Depa <i>Cer</i>	irtment e tificate	of He	ealth a Death	and M		giene Reg. No		8	23128
			1. Decedent's Name (First, Middle, L	ast)							2. Date of De. Month			ear	3. Time of Death
	Physici /Medic		Lois W. Collinge								July 12	2, 2	008	Bai	9:25 A M
	Examin		4a. Facility Name (If not institution, gr				4b. City, To			of Death		40	. County of	Death	
			Genesis Eldercar				Cent		11e	24 450			Queen		
	Funeral		5. Social Security Number 6. 577–34–0777	Sex 1 □ M 2 🛣 F	7. Age (In yrs. Ia 80	Yrs.	If Under 1		Hours	Min.	8. Date of Bin (Month, Da	y, Year)	1020	. Birthp Coun	lace (State or Foreign try)
	Director	1	Usual Residence of Decedent		00						April	15,	1920	TTT	inois
	yland		10a. State 10b. County		10c. City,	, Town or Lo	cation							1	0d. Inside City Limits
	B-f e	ctor	Maryland Queen A	nne's	Ste	vensvi	111e								1 ☐ Yes 2 🕅 No
	or 28	Director	10e. Street and Number				10f. Zip C	ode				10g. Ci	tizen of Wh	at Coun	try?
	ath w		952 Cloverfield D					2166					ited		
	er de Item	Funeral	11. Marital Status	Armed Fo		3. 13. V	Vas Deceder Yes, specify	nt of Hisp Cuban,	panic Orig , Mexican	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	-	14. Race - Black,	Americ White,	
36	irs aft	by F	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes If Yes, Gi Year or D	ve	1	□Yes 20	No No	Specify:				Specify: \	Vhit	e
9-0	2 hou	Completed	15. Decedent's 6	Education		16a. Deced	ent's Usual (Occupati	ion			16b. K	(ind of Busi	ness/Inc	dustry
21.5	thin 7	nple	(Specify only highest gi	College (lite. L	kind of work OO NOT use	retired)	inng mosi	t di workii	ng				
2	ygien ygien ygien ygien th	Con	12			Admir	istra						etail		
pue	be fill he did out	Be	17. Father's Name (First, Middle, Las	it)							(First, Middle,	Maider	n Surname)		
<u>~</u>	hould d Mei mark metic	၉	Lacy Williamson 19a. Informant's Name/Relationship	(Tuno Print)		10h Mailin	a Address (6	,	Ella		CN I Route Numbe	or City	or Tours Co	ata Zia	Codal
S	d 2 s ith an 27 le i		Karen Shafer/Daug								Stever				
ā,	tem tem	1.3	20a. Method of Disposition	IICCI	20b. Pla	ace of Dispos	sition (Name	of	1	uly			ocation - Ci		
SE	Pages ent of nt: if i		1 Burial 2 □ Cremation 3 Donation 5 □ Other (Spec		1	netery, crem hingto Ceme	+			200	8	Sui	tland	. MD	
Baltimore, Maryland 21215-0036	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow any injury or other traumetic event, the Madical Examinat must be notified at once.		21. Signature of Funeral Service Lice		1	22	. Name and	Address	of Facility	Robe	ert A.	Pum	phrey	Fun	eral Home/ sin Ave.
Ď	20 = 3		SPS	A.	MO1.	346 Be	thesd	a-Cn a, M	D 20	onas 814	e, inc.	13.	5/ W1	scon	isin Ave.
			23a. Part1. Emer the disease, or co- shock, or heart failure. List only	iplications that of	caused the death.	. Do not ente	er the mode o	of dying,	such as	cardiac o	r respiratory a	rest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Park	in Sor	ism								Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseque	ence of):	•							-	
	LAGITITIES	_	Sequentially list conditions,	b. — Due to	(of as a conseque	ater									years
· ope	ted nsit	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D08 10	(or as a consequi	erice or).									
(Dr	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a conseque	ence of):								-	·
8760	cate be chysicie the bur	dlcal		☑ d											
9		Medi	IF FEMALE									1			
š	leath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnan birth 2 ☐ Fetal		Ectopic preg	nancy					23d. Date of		•
O. E	at the dea by the at tached fo	Physician/Me	in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	4□Pregr 9□ Unkn	nant at time of dea	ath 5□	Other (spec	ify)					MONI	1	Day Year
9.	that the side by detac	P.	Part II. Dther significant conditions	contributing to d	leath but not resul	Iting in the ur	derlying cau	se given	n in Part I		23a. Did t	obacco	use contrib	ute to th	e cause of death?
Division of Vital Records, P.O. Box	uires that signed to d be det	d by	Sundanne of m	appropri	riale and	li-dir	eretie	hor	mon	ie		res 2		☐ Prob	
ço	w requir been si should	ete	There hide	1/2	riale and	400 2					24a. Was	an	24h Wa	re auto	psy findings available
Re	he lav e has age 2	Completed	Out and will	y nix	257)	ges					autor perfo	rmed?	pride	or to con ath?	npletion of cause of
ta	ysician: The is certificate hadirector, page	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes	22 No	1 1 1	J Yes	2 No -
<u>></u>	ysici lis cer direc	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1	Inpatient 2 E	ER/Outpatien	3 DOA	Other			ne 5□Resi		6 □Other	(Specify	()
0 [ttending Phys death. stor: After this or the funeral dir		27. Manner of Death Natural 5 Pending	28a. Date (Mon	of Injury oth, Day Year)	28b. Time of Injury	28c	: Injury a			28d. Describe				
Sio	death. ctor: A r the fu	catl	2 Accident investigate 3 Suicide 6 Could not	ho -			М		es 2 🗆 1						
Σį	or At after of Direct in by	Certification:	4 Homicide determined	4 288. Place	of Injury - At hor ing, etc. (Specify)	me, farm, stre)	et, factory, c	office		2	28f. Location (: City or To	Street a. vn. Stat	nd Number e)	or Rura	l Route Number,
	spitai ours s erai filled	2	29a. Certifying P	hvsician: To the	e best of my know	vledge death	occurred at	the time	date and	d place a	and due to the	causals	and man	or ac ct	atad
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending the completely filled in by the funeral director, page 2 should be detached for use as	ledical	(Check only 2 Medical Exa	iminer: On the b	asis of examination of stated.	on and/or inv	estigation, in	n my opir	nion, deal	th occurre	ed at the time,	date an	d place, an	d due to	the cause(s)
	withir To th	M	29b. Signature and title of certifier	· 6	2			_icense					ate signed (
			<i>h</i>	MINI	37 M			Di	259	33			7	.15	08
	25		30. Name and address of person who	completed caus	se of death (Item	23a) (Type,	Print)		,		Easton	1	. 1		
			31. Date filed (Month, Day, Year)	MD	610 L	with	men.	5 1	an	16	-asson	, M	1) 2	-160	2/
	Sta Registr		1111 1 8 20	08	Registrar's Signat	To the same	A. C.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 4:37AM William E. Dorsey 2008 Jul /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Sept 17, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Virginia Ĩ923 Sept 84 234-24-4248 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~- "any lijury or other traumatic event." 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ▼ No Hagerstown Director MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 USA 723 Naples Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: white 1 ☐ Yes 2 X No Specify: Be Completed by 44-46 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) vice president banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond William Dorsey Minnie Amelia McDonald ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janice Dorsey/spouse 723 Naples Drive Hagerstown, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Si natur of Funeral Service Anni hony 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 1 leas nt Baltimore, MD 21201 Ceasan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LEFT LOVER LEBE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed PARKINSONIIM burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria MENTAL ALTERto Physician/Medical (MA7US IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 ☐ Other (specify) P.O. I signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 sl autopsy performed 1 ☐ Yes 2 ☑ No certificate 1 ☐Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

of Vital Records, To the Hospital or Attending Physician: Division ours after death.
neral Director: A within 24 hours a

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

MOHAMMED

18

nhamme 31 Date filed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Ryint)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d Date signed (Month, Dav. Year)

11/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23130 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Sally Eleanor Dobrenski Ju1v 16 2008 5:20p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Hillside House Clarksville Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🙀 F Months Days Hours Min. 142-04-6556 91 Director April 6, 1917 NJ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Profest Examination of the profit of an once. MD Clarksville Howard Director 1 □ Yes 2 □XNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 13733 Green Pasture 21029 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, GiveX
Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) foods factory line worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Leck Mary ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stan Jakubik (son & executor) 13733 Pasture Green, Clarksville, MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 21 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville 7-18-08 All County Cremation 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Hargert I euseut P.O. Box 195, Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a acute cerebrovascular accident with right hemiplegia two days /Medical Due to (or as a consequence of): Examiner hypertension years Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ne y physician and ts the burial-transit law requires that the death certificate be executed Exami Due to (or as a consequence of): Box 68760. Physician/Medical as) attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 \(\sum \text{Yes} \) 2\(\sum \text{No} \) ρ Month Day Year 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 osteoarthritis 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed senile dementia 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 📉 No 1 Tyes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: ${}_{4}\square$ Nursing Home ${}_{5}\square$ Residence ${}_{6}X$ Other ${}_{6}$ Significant ${}_{5}$ 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To living this 28a. Date of Injury (Month, Day, Year) After th funeral To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certiffe D30469 July 17, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vellanki 8850 Columbia 100 Parkway, #308, Columbia, MD 21045-2377 31. Date filed (Month, Day, Year) 2008 . Registrar's Sign State Registrar

08-05377 Spencer Davis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 23131

	1- For State Registrar	State of Iviaryi		tificate of Dea			2 U U eg. No.	0 2310			
Physiciar ledical Examin	1. Decedent's Name (Fi		Leon		Davis	2. Date of Dea Month July 13, 2	th	C. Time of Death 1804 hrs			
TOMOGI EXCITING		t institution, give street and no		4b. City	, Town, or Location		4c. County of Deat				
	3628 Beehler A		7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		imore	Odlin In Data of Bir	+ (1114/DD0000/10 B)	thplace (State or Foreign			
Funeral Director	225-35-05	513 1XM 2_F	7. Age (In yrs. Ia		ider 1 Year If Under ths Days Hours	s Min		triprace (State or Foreign buntry) VA			
any	Usual Residence of Dec 10a. State 10b	. County	10c. City,	Town or Location				10d. Inside City Limits			
aryland 8a-f show at once	MD	NA	В	altimore				1 X Yes 2 No			
the Marylanc		nler Street		10f. 2	21215	1	0g. Citizen of What Cou				
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Inst. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other trannatic event, the Medical Examiner must be notified at once.	11. Marital Status 1 X Never Married	2 Married Armed F	XX No			gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Ame White, etc.	ican Indian, Black,			
ural",	3 Widowed	d Divorced If Yes, Give Ye or Dates: tion (Specify only highest gra		1 Yes 16a. Decedent's Usu	2 X No specify:		Specify: B	lack			
1215-0036 Id be filed within 72 hours after fental Hygiene, went, the Medical Examiner.	Elementary/Seconda	ry (0-12) College (1-4 or 5+)	during most of v	orking life. DO NOT		-5 PF				
5-00; ed with lygiene other t	12th grad		a 	Atte	ndent 18.Mothe	r's Name (First, Middle,	Parking Maiden Surname)	Garage			
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Realth and Mental Hygiene. Important: If item 27 is marked other thingury or other transitie event, the Med.	Leon Geor	cqe Davis Relationship (Type, Print)		10h Mailing Addre		y Ann Her	bin mber, City or Town, Stat	- Zin Codo)			
MD 21 12 should th and Me 127 is ma umatic ev	Leon Geor	cge Davis-F	ather				ews, VA 2				
Ore, jes l and of Heaf If item	20a. Method of Disposit	tion Cremation 3 Removal f		Place of Disposition (N rematory or other place		Date	20c. Location - City o	r Town, State			
Baltimore, permit. Pages I an Department of He Important: If ite	4 Donation 5 21. Signature of Funera		Met		tory Ind	¢ 7/18/08	Baltimo	re, Md			
Baltin permit Departm Importa injury o	Inet	te K- In		March 4300	F/H West	t Ave, Balt	imore, Md	21215			
Physician / Vicalical		sease, or complications that one cause on each line.			e of dying, such as o	cardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death			
xaminer *-	Immediate Cause (Fina or condition resulting in		a consequence of	omyopathy):				3000			
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ian g	X UNPENDED	X UNPENDED									
68760, certificate be uding physic se as the buri		nant in the 1 Live		2 Fetal dea	th 3 Ectopi	ic pregnancy	23d. Date of delive Month	ry Day Year			
Box 68 e death certification and the attending ed for use as	23b. Was decedent preg past 12 months?		nant at time of dea own	oth 5 Other (S	pe cify)						
P.O. es that the igned by the detache	Ŝ.	nt conditions contributing t	o death but not re	sulting in the underly	ng cause given in P		obacco use contribute to				
of Vital Records, ng Physician: The law require ther this certificate has been signeral director, page 2 should be						24a. Was auto	psy prior to	utopsy findings available completion of cause of			
tal Recolant The la certificate has ector, page 2	5					perfo 1 ✓ Yes	ormed? death?	res 2 No			
ital sician: is certificactor	25. Was case referred t examiner?	Hospital:	Inpatient 2	ER/Outpatient 3	26.Place of Death	(Check only one) Nursing Home 5	Residence 6 V Other	er Scene			
n of Vi ding Physi After this funeral dir		28a. Date (Mont		28b. Time of Injury	28c. Injury at World	k? 28d. Describe	how injury occurred	. Justice			
Division o Spital or Attending nours after death. neral Director: Aft filled in by the fune	Accident Suicide 6	Investigation	e of Injury - At ho	me, farm, street, facto	1 Yes 2 pry, office building, e	etc. 28f. Location (tural Route Number, City			
Divi	4 Homicide	determined (Specify)				or Town,	State)				
Division To the Hospital or Attent within 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the		tifying Physician: To the be lical Examiner: On the basis	of examination ar								
F. 18 F. 8	29b. Signature and title	of Certifier	stateu.		9c. License number	T	29d. Date signed (M	onth, Day, Year)			
	(aun	when	on of death ()	230)	O.C.M.E.		July 14, 2008				
	Laron Locke M	of person who completed cau D. Assistant Medica		111 Penn Stre	et, Baltimore, M	MD 21201					
Stat Registra	e 31. Date filed (Month, D	ay1Ye8) 2008	egistrar's Sign	· Bould							

			_	ype or Print in B State of Maryland				-	_	ble.		
		1	1 - For State Registrar	·		rtificate of		Reg. No 2008 23 32				32
			1. Decedent's Name (First, Middle, Last)					2. Date of De Month		Year	3. Time of Dea	
	Physicia /Medic		Helen Marie DiVe	nti				July	17	2008	2:00	Рм
	Examin		4a. Facility Name (If not institution, give s	treet and number)			or Location of Death	1	4c. County			
_			Genesis Severna Par 5. Social Security Number 6. Sex		nat historiani	Severn	la Park	9 Date of Bir		Arun	de l ice (State or Fo	oreian
ì	Funeral Director			7. Age (In yrs. la 82	Yrs.	Months Days		8. Date of Bir (Month, Da 03-06-	1, Year) 1926	Mary	y)	Ureigii
	yland Now		10a. State 10b. County		Town or Lo					10	d. Inside City L	
:	e Mar la-fsl	cto	MD Anne Arui	ide I Sever	rna Pa	rk					1 ☐ Yes 2	No
3	illed within 72 hours after death with the Maryland Hygiene. Hygiene. Then "hatural", or items 23a or 28a-f show ant, it a Madical Examitment be notified at ant.	Funeral Director	715 Benfield Road	, #112		10f. Zip Code	21146		10g. Citizen of \U.S		y?	
	tems tems	mei	77. Marital Otatas	2. Was Decedent Ever in U.S Armed Forces?	i. 13. \	Was Decedent of f Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No o Rican, etc.)	o- 14. Rad Blad	ce - America ck, White, et		
	"natural", or items	þ	1 ☐ Never Married 2 ☐ Married . 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 📉 No If Yes, Give Year or Dates:	1	1∐Yes 2⊠No	Specify:		Specif	,,,,,		
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1 3	withili iene. • than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		etary	<i>,</i>		State o	of Mar	yland	
3 3	e filed withir	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle				
= :	nould be filed with the Mental Hygiene. marked other that matic event, the Mental Matic	To B	Charles Sodi	9			Jan	nie Man	del			
3	is should be lifed within 72 hi th and Mental Hygiene. 7 is marked other than "natu traumatic event, it a fredical		19a. Informant's Name/Relationship (Typ		l	•	et and Number or Ru					
•	and tealth m 27 her tr		Charles DiVenti /				Guinever	e Way,	Chester,		21619	
	permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is man any injury or other traumat once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	ce	metery, cren	sition (Name of natory or other pl of Faith	o7-2	21-2008	Baltim	•		d
3	Depart Depart Import any In		21. Signature of Funeral Service License			2. Name and Add			son Fune		ome, In	IC.
	20 = 60		23a, Part 1, Enter the disease, or complic	ude			k Road T		7-1-1		Approximate	
			shock, or heart failure. List only one immediate Cause (Final			I \	1 1		mest,		Interval Betwee	en ath
	hysician /Medical xaminer		disease or condition resulting in death)	Due to (or as a consequ	ence of):	mall	_ ble	ed		Ċ	3 days	<u> </u>
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4	re executed sian and urlal-transit	Examiner	Cause (Disease or injury that initiated events									
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3	ng ph) as th	Medi										
The least the state of the stat	the attending p	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	ic. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnar Other (specify)	ncy		l l	ate of deliver onth [y Day Yea	ar
	ned by the a		Part II. Other significant conditions cont	ributing to death but not resul	Iting in the ur	nderlying cause g	iven in Part I.	23e. Did	tobacco use con	tribute to the	cause of deat	uth?
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100	ning ringsicial. After this certificant funeral director,	To Be	examiner?	ospital:	ER/Outpatier	nt 3 DOA	thor:		idence 6 Ot	her (Specify)	
2	After th	ï.	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		ury at ork?	28d. Describe	how injury occur	red		
Attending Physiologics	death. ctor: Al	atic	2 ☐ Accident investigation]Yes 2 □No					
	# # # F	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (City or To	(Street and Numi wn, State)	ber or Rural	Route Number	т,
I defended only	Funel tely fil	Medical		ician: To the best of my knov er: On the basis of examinat								
od to	ithin (Med	296. Signature and title of certifier	and manner stated.		29c. Lice	nse number		29d. Date signe	ed (Month, £	Day, Year)	
F	7 7	1			MD	1	507	25	7-1	7-	200	8
1	0	4	30. Name and address of person who cor	npleted cause of death (Item	23a) (Type,	Print)	507 a	avolate	10 7	MN	2116	75
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure 1034		1 will	W/ UVIG	, ,		- '/	0
	Registra	ar I	THE TO COUL	A Property	6 1							

			•	pe or Print in B State of Maryland					no -	00123		
		•	For State Registrar	,, ,, ,	•	tificate of			2008	23133		
	Physicia /Medic		Decedent's Name (First, Middle, Last) ELEÁNOR			DANI	IELS J		15 2008	3. Time of Death 8:22A M		
	Examin		4a. Facility Name (If not institution, give stre ANNE ARUNDEL MED:			4b. City, Town, or ANNAP(r Location of Death		4c. County of Death ANNE ARUNDEL			
	Funeral Director		5 Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8	Date of Birth Month Day, Ye	9. Birtl	nplace (State or Foreign untry)		
	ס		Usual Residence of Decedent	100 City	, Town or Lo	nation				10d. Inside City Limits		
	Maryla f sho	ō	10a. State 10b. County PRINCE GI		BOWIE	oution			i	1 ☐ Yes 2 ሺ No		
	or 28a	Funeral Director	10e. Street and Number		30.112	10f. Zip Code		10g.	. Citizen of What Co	untry?		
	s 23a	erall	15569 PEACH WALKE	R DRIVE Was Decedent Ever in U.S	2 12 1	Mas Decedent of H	20716	v Ves or No-	USA 14. Race - Ame	rican Indian.		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Redical Eventine I hast by Intiffic at ance.		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Was Decedent Ever in o.s Armed Forces? 1		Vas Decedent of H fYes, specify Cuba 1 □Yes 2 X No	Black, White					
15-0	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Sive kind of work done during most of working life. Do NOT use retired) 16b. Kind of Business/Industry (Do NOT use retired)											
212	d withir giene. r than	Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR CENSUS BUREAU COLLEGE (1-4or 5+)										
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Baltimore,	Pages 1 annent of He ant: If item ary or othe		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 X Ren	noval from State 20b. P	lace of Dispo emetery, crer ARAR	sition (Name of matory or other place AT CFMFT	ce) Date		c. Location - City or FARMINGDA			
altin	permit. Page Department of Important: If any Injury or once.		1 LABurial 2 □ Cremation 3 Maremoval from State 4 □ Donation 5 □ Other (Specify) MT. ARARAT CEMETERY 07/17/2008 FARMINGDALE, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC.									
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- Marine	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.		a tiè	(0) 0		ncer	Interval Between Onset and Death		
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9289	rtificat ing phy as the	Medi	IF FEMALE:									
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	i. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	☐ Ectopic pregnand ☐ Other (specify)	су		23d. Date of de Month	livery Day Year		
rds, P.	luires that n signed b ild be deta	by	Part II. Other significant conditions contri	buting to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac	/	o the cause of death?		
Records,	: The law requir cate has been s , page 2 should	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of		
Vital	ician: The certificate ector, pag	Be C	25. Was case referred to medical examiner?	anitali.		Low	26. Place of Death (Check only one)				
of	Physi r this c eral dire): To	1 Yes 2 No	28a. Date of Injury	28b. Time o	nt 3 🗆 DOA		d. Describe how	ce 6 ☐ Other (Sperinjury occurred	ecify)		
ion	ath. rr: Afte	atior	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury		rk?]Yes 2 □No					
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st y)	reet, factory, office	28	f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,		
	e Hospita 24 hours e Funeral letely filled	dical (29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	cian: To the best of my knoer: On the basis of examina and manner stated.	wledge, dea ition and/or in	th occurred at the the threat the threat thr	time, date and place, ar opinion, death occurred	nd due to the cau d at the time, date	use(s) and manner a te and place, and du	e to the cause(s)		
	To the within To the comple	Me	29b. Signature and title of pertifier	1	10	29c. Licen	se number	290	d. Date signed (Mon	th, Day, Year)		
	10 1		A	pleted cause of death (Iten	A	7		MI		enter		
	Sta Registi		31. Date filed (Month, Day, Year)	7. Registrar's Signa	ture	ales	-nae.I	1 17 010				
	9.51		20110									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 07-15-2008 1112 A M James Eliopoulos /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Hospital 8. Date of Birth Month, Day, Year 10-25-1932 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Days 1 ★M 2 ☐ F Yrs MD 212-30-8406 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 27 No Director Bel Air Harford 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21015 USA 1502 Willowdale Drive Funeral 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Eliopoulos Pauline Bovrazeli ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia Eliopoulos (Wife) 1502 Willowdale Drive Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 07-18-2008 | Parkville, MD 4 □ Donation 5 □ Other (Specify) St. Demetrios Cem. 22. Name and Address of Facility Schimunek Funeral Home of Bel Ai 21. Signature of Funeral Service Lensee 6-Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ardiomyopath 2-3415 disease or condition resulting in death) Due to (or as a consequen of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Diabete Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 renal disease, hypertension 212 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Parkinsons disease 24a. Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

this certificate har ral director, page

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any Injury or other traumatic excess.

Physician

/Medical Examiner

Lobou los James ITI8003444 within 24 hours after

To the Funeral Directory

completely filled in b

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number

29b. Signature and title of certifier

who com

hesapeake

30 Name and addless of person.

Upper

29d. Date signed (Month, Day, Year) BelAir MD 21014

State

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DHMH 17 Rev 1/2001

eted cause of death (Item 23a) (Type, Print)

Registrar's Signature

Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year CLARENCE AKEHURST ECK 4:55P[™] 2008 JULY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 11 DELIGHT AVENUE BALTIMORE COUNTY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 ☑ M 2 □ F 219-36-0135 89 Sept.12,1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2√2No Baltimore Baltimore County Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ll Delight Avenue 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes X No If Yes, Give Year or Dates: 1 Never Married A Married 1 ☐Yes 2√ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) G. Clarence Eck 12 yrs. College (1-4or 5+) & Son Horticulturist yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Clarence Eck Elsie Martin Akehurst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia S. Eck (Wife) ll Delight Avenue Baltimore. Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cem. :7-17-2008 Baltimore, Md. 4 □ Donation 5 🖾 Other (Specify) Entombment 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral 7401 Belair Rd. Home Baltimore, Ç, dassah Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) trury mi Due to (or a a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): stadder Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown litions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ∐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 40212W 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy perform 1 □Yes 2 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Inpatient □ DOA 6 ☐ Other (Specify)

Physician /Medical Examiner

permit. Pages 1 and Department of Health Important: if item 27 any Injury or othar tr once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exprised in the Indiffed an

s 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

this

within 24 hours after death

To the Funeral Director:
completely filled in by the 1

death.

After thi funeral

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Physician/Medical

signed by the attending to be detached for use as δ s been si should t Completed cate has by page 2 s certificate director, Be Medical Certification: To

23b.	Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown
Part	II. Other significant cond

28a. Date of Injury (Month, Day,

and manner stated.

1 ☐ Yes	21 2 No
27. Mann	Death
1 Matura	al 5 ☐ Pend
O T A sold	inves

3 ☐ Suicide

4 ☐ Homicide

ding stigation 6 ☐ Could not be determine

2 📖	EH/Outpatient	3 L
(ear)	28b. Time of Injury	М

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

28d.	Describe	how	injury	occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation

red at the time, d	late and place, a	nd due to the c	cause(s) and ma	anner as stated.	
tion, in my opinio	n, death occurre	d at the time, d	late and place,	and due to the d	cause(s)
	_				

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20 M.D. 31. Date filed (Month, Day, 8 2008 32: Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State	State of Mar		artment of Hertificate of E		, ,		0.8	23136
		Registrar 1. Decedent's Name (First, Middle)		^	tillcate of L		2. Date of Dea	th		3. Time of Death
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21215-0036 d within 72 hours af giene. er than "natural", or the Medical Exami	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					Specify:	ьта	
in 72 h	Completed	15. Decedent (Specify only highes	t grade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	lurina most of wo	rking	16b. Kind of Bus	siness/indus	stry
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Ind 21215- be filed within 72 ttal Hygiene. d other than "naf event, the Medics	e	17. Father's Name (First, Middle,	Last)		1		me (First, Middle,	Maiden Surname	e)	
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or Health		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location - 0		
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Baltimed permit. Pag Department important: I any Injury o		21. Si v at., e of Funeral Service	Licensee	Ma	2. Name and Addres rch F/H 800 Waba:	West	, Balti	more, N	1d 2	1215
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Box 6 Meath certifi attending	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1□Live birth 2		∃Ectopic pregnancy				e of delivery	
	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti		Other (specify)			Mor	nth D	ay Year
P.O that the		Part II. Other significant condition	ons contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contr	ibute to the	cause of death?
Records, P he law requires that has been signed t ge 2 should be det	d by						1 🗆 Y	es 2 No	3 ☐ Probat	bly 4 Unknown
as bee	Completed						24a. Was autop	an 24b. V	Vere autops	sy findings available
The lay	Som						perfor	rmed?	leath? `	□ No
Vital Risidan: The certificate hisector, page	Be	25. Was case referred to medical examiner?	Hospital:		Othe	or /	ath (Check only o			
Phys this al dii	2	1 Yes 2 1 Ne 27. Manner of Death	1 ☐ Inpatient		11 3 DOA	4 Mursing I	Home 5 Resid	lence 6 Othe		
ion nding tth. r: Afte e fune	ation	1 Natural 5 □ Pendin 2 □ Accident investig		Year) Injury		k? Yes 2 □ No				
Division or all or Attending Physical Externation of Intercept of Inte	Certification:	3 Suicide 6 Could r 4 Homicide determ		y - At home, farm, str (Specify)	reet, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	er or Rural I	Route Number,
Division or Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical C	29a. Certifier 1 ☐ Certifyir (Check only ong) 2 ☐ Medical	g Physician: To the best of Examiner: On the basis of e and manner state	examination and/or in	h occurred at the tim exestigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place, a	nner as stated	ted. the cause(s)
To th withir To th	Me	29b. Signature and title of certifie		han n	29c. License			29d. Date signed		_
,		pully /	1718641	(14), 1	V71 10	05641	4	7-15	-20	308
6		30. Name and address of person	with completed cause of dea	th (Item 23a) (Type,	H 9109	Libera	ty Road	d, Rg	ndal	Ustown,
S Regis	tate trar	31. Date filed (Month, DAy, Year)	2008 32 legistrar	's Signature	Well -			,		-1135

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 7 15 2008 Marion Geneva Ferguson 10:55a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Levindale Geriatric Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 24 9. Birthplace (State or Foreign **Funeral** Year 35 1 □ M 2 🗶 F Director 251-56-2740 Usual Residence of Decedent SC death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the <u>Medical Examiner must</u> be notified at 1X Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Apt. 403 Completed by Funeral 3800 W. Belvedere Avenue 21215 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ould be filed within 72 hours after or Mental Hygiene. 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2K No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 11th 17. Father's Name (First, Middle, Last) N/A18. Mother's Name (First, Middle, Maiden Surname) Be Louise Bates P 1 and 2 should Dave Cromer and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 3735 Elmora Avenue Baltimore, MD 21213 Thomas Ferguson-son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any Injury or ott 1 urial 2 Cremation 3 Removal from State King Memorial Pk.7/21/2008 Baltimore Co. MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST B I ade 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiothrombotic Event /Medical **Examiner** ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events ding physician and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: Nursing Home 5 Residence 6 Other (Specify) ပ 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 9/16/08 00057465 1apaluse MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reisterstown, MD. 21136 N.S. Ray apakse MD 25 Main Sty Suite & 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Searle

DHMH 17 Rev 1/2001

MUNION

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** July <u>Charles James Falanga</u> 2008 10 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 2727 Harford Rd. Harford

9. Birthplace (State or Foreign Country) Fallston Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 216-28-9780 Director 76 11/07/1931 NY Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the fredical Experience must be a diffied a 1 □Yes 2 No Director Harford Fallston MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2727 Harford Rd. 21047 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 1 Never Married 2 Married 1 Yes 2 2 □ No Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 1950 - 1953 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Flower Shop Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental F Vincent James Falanga Lillian Ducey ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Is r Health a permit. Pages 1 an Department of Healt Important: If Item 27 any injury or other traonce. Craig Falanga/Son 2727 Harford Rd. Fallston, MD 21047 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jul. 14, Beltsville, MD Cheasapeake Crem. 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CAFA/Stephen D. Lohrmann P.A. Green Pastures Dr. Towson 21286 8717 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neeus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner Due to (or as a conse vience of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): ending physician a use as the burial IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? for Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 2 □ No 1 □ Yes 2 **I** No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\overline{\text{Residence}}\) 6 \(\sum \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Mann Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 Pending Injury n 24 hours after death.

In Funeral Director; Af olderely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on one) within 24 and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature D45390 17th 2008

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

8

32 Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Road #200, Bel Air, N.D. 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ye ar **Physician** Q Joseph Weaver Garrett 3006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Security Number CON SCE If Under 1 Year Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min. Months Days 1 X M 2 □ F Director 218-28-3196 76 15 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County perritt. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depurtment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinations inset the rectified at N/A MD 1 TXYes 2 □ No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Apt. 810 Funeral 1102 Druid Hill Avenue 21217 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 34☐ If Yes, Give Year or Dates: 1x Never Married 2 Married 3/TXNo 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th N/A Disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Garrett Maggie Brown ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 Suite 620 Baltimore, Arthur L. Drager, LLC N. Calvert St. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. 7/18/2008 Baltimore Co. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST Avenue Baltimore, MD 21202 公 la 1101 E. North Avenue Baltimore, OL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** therose disease or condition resulting in death) /Medical (or as a consequence of): Examiner 200 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 0 Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Division of Vital Records, P.O. Box 68760, the as the signed by t page 2 should has certificate this After 1 death. 24 hours after death Funeral Director: filled in by completely

death with the Maryland

Baltimore.

28a-f show

20

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

197cm

Year

2008

State

Registrar

32 Registrar's Signature

and manner stated.

11 Macon

MARKE

within 2

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

RYGET Baltimore,

Physician /Medical **Examiner**

Division of Vital Records, P.O. Box 68760;

State of Maryland / Department of Health and Mental Hygiene

1- State Amend #30 per DVR, g881 7/18/08/TTT Registrar

Registrar

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Maryann 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Cente Baltimore Washington GLEN BURNIE ANNE ARUNDEL 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 M 2 X F Months Days Hours Min 220-60-9956 56 Director 5, 1951 MARYLAND AUG. Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla pepartment of Health and Mental Hygiene. Important: I flean 21 a marked other than "natural", or Items 23a or 28a-f show any injury to other traumatic event, the Meritea Experies on the traumatic event, the Meritea Experies on the confiling a 1 ☐ Yes 2 XNo Director MARYLAND ANNE ARUNDEL SEVERN 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 344 CONSTANT AVE. 21144 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: WHITE <u>6</u> Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) WAREHOUSE WORKER 12 TRUCKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM EDWARD ANDERSON ပ JEANETTE VIOLET STOUT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM GRIMM / HUSBAND 344 CONSTANT AVE., SEVERN, MARYLAND 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State JULY 21, 2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GLEN HAVEN MEM. PARK GLEN BURNIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) eture of Foreral Serv 21. Sign KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 0 23a. Part tenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cnit Ca Due to (or es a consequence of): Smok Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Vear Day 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 **N**o 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death

To the Funeral Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 3 50254 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahador Momeni, MD Baltimore Washington Medical Ctr. GLen Burnie MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0941 AM **Physician** HARDING DELANE 2003 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NIA BALTIMORE JOHNS HOPKINS BAYNEW MEDICAL CENTER 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year Social Security Number Year) **Funeral** Hours 1 ☐ M 2 🔀 F Months Days 89 Yrs. NC. 244.70.447 Director 0 Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exposition at Baltimore 1 ☐ Yes 2 No ND Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Gough Street 7738 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Black <u>6</u> 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Inc. Mex. College (1-4or 5+) /Secondary (0-12) Day Care Center Care Worker 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name First, Middle, Last) UNK Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7738 Gough Street SON Balto. MD 21224 Harding 20c. Location - City or Town, State 20b. Place of Disposition (Naive of cemetery, crematory or other 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08 Washington, NC 07 24 Facility V C. Oreene tuneral SNO 21. Signature of Funeral Service Licensee qua Randallstown MD 21133 Road Var 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COAGULATION 24 hours INTRAVASCULAR **Physician** DISSEMINATED disease or condition resulting in death) /Medical 96 hours Examiner SEPTIC SHOCK if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transi and Due to (or as a consequence of): P.O. Box 68760, physician The law requires that the death certificate be Physician/Medical as the attending IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ctopic pregnancy
5 Other (specify) Month Day o signed by the a d be detached fo 1 ☐ Yes 2 X No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 X Vo 2 No 1 ☐ Yes 1 Yes funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t After 1 Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2008 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 4940 BALTMORE EASTERN KAMIN HERATI

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

UUO JAMENES JO JOSEPHERE

Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

		•	For State Registrar	State of Mary		tificate of D		F	leg. No.		23142	
F	Physicia /Medic		1. Decedent's Name (First, Middle, Las.	OLEY				2. Date of Dea Month	Day	1008	3. Time of Death	
` /	Examin		4a. Facility Name (If not institution, give Johns Hopkins Bayy			4b. City, Town, or L Balt:	ocation of Death		4c. Count	y of Death N/A		
	uneral rector		5. Social Security Number 6. Se 217–18–1165		n yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Da) April 10	, Year) 1923	9. Birthplac Country Pennsy.		
ryland	te i	<u>.</u>	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d	. Inside City Limits 1 ☐ Yes 2 X No	
h the Ma	r 28a-f s rrottfie	Director	Maryland Baltimon	re	Dundal	k 10f. Zip Code			10g. Citizen of	What Country		
ath wit	s 23a c		8346 Bletzer Road	12. Was Decedent Ever	in II S 13 5	212:		necify Yes or No-	USA 14. Ba	ce - Americar	Indian.	
nours after de	al", or item xominer r	by Funeral	11. Marital Status 1 Never Married X Married 3 Widowed 4 Divorced	Armed Forces? 1 Y Yes 2 □ No If Yes, Give Year or Dates:	I .	Was Decedent of His If Yes, specify Cuban 1 □Yes 2X No		Rican, etc.)		ock, White, etc fy: White		
hin 72 hou e.	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner mast by notified at		15. Decedent's Ed (Specify only highest grad	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of work	ing	16b. Kind of E	Business/Indu	stry	
iled witi	ther the	Completed	7 years 17. Father's Name (First, Middle, Last)		Mac	hinist	18. Mother's Nam	e (First, Middle,	Ste Maiden Surna			
should be f	rked of tic eve	To Be	Timothy Hooley				Elsie L	ydic				
12 short	7 is ma trauma	ľ	19a. Informant's Name/Relationship (7			ng Address (Street and Number or Ru Bletzer Road, Dur				n, State, Zip C 2122 2	code)	
ages 1 and int of Health	Important: If item 2 any injury or other once.		Catherine Hooley 20a. Method of Disposition 1	Hemoval from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place Crematory		Date 21,	20c. Location Baltimo	- City or Tow		
permit. Pages Department of	Important any injury once.		21. Signature of Fuheral Service Licen			Name and Address Onnelly Fi 110 Solle:		00			21222	
/M	i physician and edical stree burial-transit	al Examiner	23a. Part 1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
requires that the death certificate		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown				Date of deliver	y Day Year				
v requires that	signed b	<u>Ş</u>	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	inderlying cause give	n in Part I.		obacco use co Yes 2 □ No		cause of death?	
The law	 funeral director, page 2 should be detached for use a	Completed						1 □ Yes	ormed? 2 10 No	sy prior to completion of cause of death?		
9)	nis certi directo	ro Be	25. Was case referred to medical examiner? 1 Yes 2 Yo		2 ER/Outpatie	nt 3 DOA Othe	26. Place of Dea f: 4 ☐ Nursing H	lome 5 ☐ Resi		ther (Specify,)	
tending Phy	To the Funeral Director: After the completely filled in by the funeral	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 □ Y	rat ? ∕es 2 □ No	28d. Describe			On the Number	
ital or Attending	ral Direct	Certifi	4 ☐ Homicide determined	building, etc. (Specify)			City or To	wn, State)		Route Number,	
e Hosp	e Fune	ledical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exar	nysician: To the best of n piner: On the basis of ex and manner stated	amination and/or i	th occurred at the time time time time time time.	ne, date and place pinion, death occu	e, and due to the urred at the time,	date and plac	e, and due to	the cause(s)	
To th	To th comp	Me	29b. Signature and title of certifier	/	th.	29c. License			29d. Date sign	*		
	\land		30. Name and address of erson who			Print)	- 000	3	, vury	10,	2008	
	Sta	ato.	31. Date filed (Month, Day, Year)	/JUN ARIV		40 EAST	ERN 1	TUE, B.	All mi	RE, M	0 5/55	
	Jli	110	1111 1 8 20	08 18 18 18 18	B. At	THE STATE OF THE S						

DHMH 17 Rev 1/2001

Certificate of Death

Mitchell /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayvico medical Genter Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Jan. 18, 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Year) 1944 Months Days Hours 1**X** M 2□ F Jan. 64 212-44-5848 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 156 Chestnut Street 21222 U.S.A. by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene, Dock Worker 11 Longshoreman is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Mitchell Henry Beatrice Moss injury or other traumatic ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 in any injury or other tra Beatrice Moss Henry (Mother) 156 Chestnut St., Baltimore, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lacks Family Cemetery 7/15/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Jeffress Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Jeptic Shock disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter or nearlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Mo Iti lobar Meunionia Due to (or as a consequence of): aftending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ Completed 24a, Was an s certificate has be irector, page 2 sl 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide

1. Decedent's Name (First, Middle, Last)

Physician

20c. Location - City or Town, State Clover, VA 2000 N. Main St., South Boston, VA Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 2 No 1 □ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) RES-000 09, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltinura Eastern trenue 4940 MD 3 Registrar's Signature **ORIGINAL**

2. Date of Death

09

2008

14. Race - American Indian, Black, White, etc.

Specify: Black

4c. County of Death

Month

エリ

3. Time of Death

12:30 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 XYes 2 No

Country) Virginia

State Registrar

Medical

(Check only one)

Ashleigh

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Hicks

M. D.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** mm 25 +au 2008 /Medical 4c. County of Death give street and number) 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, **Examiner** tospila NOIL emoria TIMO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 2 M 2 □ F 237-46-433 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a 10b. County 10c. City, Town or Location or 28a-f show or other traumatic event, the Wildigal Examinar must be notified at **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces 2 14. Race - American Indian, or items 11. Marital Status Black White etc. 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify 2 3 Widowed 4 Divorced Year or Dates "natural" Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) attendant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship, (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12s 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name and Address of Facility UNZIL BERTY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** to Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. if yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. I 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 24a. Was an performed this certificate 2 ☑ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one)

D,0,

egistrar's Signature

D.O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ta 110 18. Mother's Name (First, Middle, Maiden Surname) 20c. Location - City or Town, State ells TOWN BOW. MI 2407 Approximate Interval Between Onset and Death 48 hours 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Memorial

Year

11:08 A.M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Yes 2 No

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

Union

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day ZDAM Month **Physician** GAIL HARRIC 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMDRY RANDALLSI If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛛 F Days 63 Director Sept. 1944 438-66-8343 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Medical Exercity to must be notified at 1 □Yes 2√2 No Funeral Director **Baltimore** MD Reisterstown 10g, Citizen of What Country? 10e. Street and Number 10f Zin Code 730 Cockeys Mill Road USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 📆 No Specify. Specify. Completed by 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Media Specialist Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ John Bentz Lorraine Flynn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other troonce. 730 Cockeys Mill Road, Reisterstown, MD 21136 Benjamin S. Harris, II Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7/15/08 Carroll Cremation Hampstead, MD 21. Signature of Funeral/Se 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home 23a. Part 1. Enter the disc shock, or heart faild Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ARTENINSCLERDTIL CAROIDVACCULAR /Medical Due to (or as a consequence of): Examiner LMDWAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68766 attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an Was a. autopsy performed? Yes 2 2 2 2 10 certificate 1 ☐ Yes 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🛂 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANDALLSTOWN, MARYLAND FABER DED COVET RVAO 32. Registraris Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last), 2. Date of Death 3. Time of Death Month **Physician** /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BRIVE 00 eona Lonowing Birthplace (State or Foreign Country) 5. Social Security Number 215-28-2184 If Under 1 Year | If Under 24 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Hours 1**Д** М 2□ F Une 22, 1931 BALTIMORE ME Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Mcdical Examiner must be notified at 1 ☐ Yes 2X No Director onowingo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: filem 27 is marked other than any injury or other traumatin. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 48. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Conol 1000 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Frans Funeral Chapel-Balltin Hill, MO 21050 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year ed by the detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 from Nown To the Funeral Director: After this certificate has been single funeral Directors. After this certificate has been single funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 1 □ Yes 2 □ No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day, Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8X1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St 31. Date filed (Month, Day, Year) 32#Registrar's Signature State 1 8 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 12:37 AM Peggy J. Hipkins 1014 008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ty 0 hospital baltimure itmore 9) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 😿 F 212-46-3809 Maryland **Director** 11/17/1921 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Parkville Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 8820 Walther Blvd. Apt. 4202 21234 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: White Be Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within At Home n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker laryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be Helen Marie Foster Raymond Roy Insley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 14628 Sailboat Circle Midlothian, VA 32112 Patricia Owings/ Daughter permit. Pages 1 and Department of Heall Important: If item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of Evants, Fundor of The Place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/18/08 Chapel-Forest Hill, MD Bel Air 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a Par I. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shyck, or heart failure. List only one cause on each line. nate Cause (Final **Physician** disease or condition resulting in death) Hemseshore due to light iliac aftery in way /Medical Due to (or as a con equence of): Examiner La do soscular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🕏 cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): SEMINFORTON NA MOVED BY MEDICAL Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 🕱 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 🗱 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral. 28b. Time of Injury 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending Investigation -3:00 PM 1 □Yes 2 ☑No In Jury 7-15-08 operative 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 2 401 U. Belvedere determined 4 Homicide at Sinai Hospiter Baltimore, MD 21215-5271 To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 68810 05 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) halon MD WON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1.8 Registrar

9

			1- For State of Maryland / De State of Maryla	ppartment of Health and Mer Certificate of Death	ntal Hygien Reg. N	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Lillie M. Heitzer	2.	Date of Death Month	Day 2005 10 A M
	Examin	1.45	4a. Facility Name (If not institution, give street and number) 4131 Doris Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		Date of Birth (Month, Day, Yea	tc. County of Death N/A N/A 9. Birthplace (State or Foreign Country) Maryland
	Director		218 07 7343		6/08/191	
	Marylan a-f show ffied at	tor	Maryland N/A Balti			10d. Inside City Limits 11 Yes 2 No
	h with the 3a or 28a st be not	al Directo	10e. Street and Number 4131 Doris Avenue	10f. Zip Code 21225	10g. 0	Citizen of What Country? U.S.A.
920	within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notiffed at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 No Specify:	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 ho iene. • than "natur the Medical I	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of working fe. DO NOT use retired) eamstress	10	Kind of Business/Industry Sewing Factory
and 21	be filed htal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last) Adam R Jacobs Sr	18. Mother's Name (F		
	d 2 sho th and 7 Is m traum	To	19a. Informant's Name/Relationship (Type. Print) 19b. N	Mailing Address (Street and Number or Rural F B1 Doris Avenue Bal		y or Town, State, Zip Code) Maryland 21225
Baltimore,	permit. Pages 1 an Department of Heali Important: If item 2 any injury or other once.		1 M Burial 2 Ucremation 3 Unernoval from State	isposition (Name of crematory or other place) ill Cemetery 07/07/ 22. Name and Address of Facility Gonc	2008 Ba	Location - City or Town, State Itimore, Maryland I Service, P.A.
	Physician /Medical		23a. Part. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)	t enter the mode of dying, such as cardiac or re		Approximate Interval Between Onset and Death
68760,	ficate be executed by physician and ts the burial-transit	edical Examiner		c Cardiovascular Dise	ase	
O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that been signed by should be deta	þ	Partition of the significant conditions contributing to decur but not resulting in	he underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
or Vital Records,		Completed			24a. Was an autopsy performed 1 Yes 2	
r Vita	Physician: The this certificate haral director, page	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	26. Place of Death (0 atient 3 DOA Other: 4 Nursing Home		e 6 □Other (Specify)
Division o	or Attending Ifter death. Director: After in by the fune	Certification:	27. Manner of Death Natural 5 Pending 28a. Date of Injury (Month, Pay Year) 28b. Tir Injury	ury Work? M 1 ☐ Yes 2 ☐ No	d. Describe how in Location (Street City or Town, St	and Number or Rural Route Number,
	ne Hospital n 24 hours a he Funeral I	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, the basis of examination and manner stated.	or investigation, in my opinion, death occurred	at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License number D 15876 ype, Print) M A in Sheek	2 J	Date signed (Month, Day, Year)
	(10)	5.5	30. Name and address of person who completed cause of death (Item 23a) (THROLD BOBMD 25	ype, Print) MAIN Sheek		21136
	Sta Regist		31. Date filed (Month, Day, Year) JUL 1.8 2008 32. Registrar's Signature	de		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 14 5 /Medical wn, or Location of Death 4c. County of Death ility Name (If not institution, give street and number) Examiner mor If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 7. Age (In yrs. last birthday, **Funeral** Days NDM 2□F Months Min. BARD Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State show 1 Nes 2 No item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at Funeral Director MORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2121 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: filed within 72 hours after Married 1 Never Married NIA 2□No Yes Specify: Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. om 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) KEGEncy Hotel 18. Mother's Name (First, Middle, Majden Surname) Father's Name (First, Middle, Last) Be 001 ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship, (Type. Print) Department of Health a Important: If item 27 is any injury or other tra once. TO hdA Date 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee BAI 23a. P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each limb. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heans Vivelobbnosis **Physician** //Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit requires that the death certificate be execu Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown 9 🗀 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21 No has certificate 1 ☐ Yes Division of Vital e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date şigned (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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Manshall H 31. Date filed (Month, Day, Year) JUL 18

2808

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

6569

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 0 8

G881 7/23/08 Tertificate of Death

Reg. No. 1- For Amend #7, perFH Ragistrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 15,2008 Year Albert R. Jackson Sr 0830 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Ft Washington Ft Washington Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 X F Director 579-20-2272 YIS. Decatur, AL May 15,1915 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 □ No Completed by Funeral Director Maryland Prince George's Ft Washington 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 12306 Gable Lane United States 20774 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Eleventh** DC Transit None Foreman 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any linury or other traumatic event ODEs. 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ Frank Jackson Clara (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5115 Reis Circle, Fayetteville, New York 13066 Michelle Grandy/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 7/18/08 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory Riverdale Maryland 21. Signature of Furreral Se 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 1661 good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 days /Medical Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause (Disease or injury that initiated events resulting in death) Last Hospifal or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed Dehydration 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed MAINUTRITION /s after deau.. ral Director: After this co...

in by the funeral director, pr 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospifal of within 24 hours at To the Funeral D 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0033512 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 11701 Lingston Rd. Ste 203, FT. WASHINGTON Deidra Varrer 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Day 2008 Year **Physician** 14 William Armour Jenkins III Ρм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Apr. 19, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 ☑ M 2 ☐ F 220-07-1158 88 Marvland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #2403 21234 USA 8810 Walther Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married , or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 XWidowed 4 ☐ Divorced white "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ite Mone. Elementary/Secondary (0-12) College (1-4or 5+) Quality Technician Procter & Gamble 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Armour Jenkins Jr. Katherine A. Amos ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Meadowcroft Lane; Lutherville, MD 21093 Ellen Harrington daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 A Cremation 3 ☐ Removal from State Hydes, MD St. John the Evangelist 7/24/08 4 □ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livers 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia AY /Medical Due to fr as a consequence of): Examiner newittes Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit moltiple Stroles Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 1 □Yes 1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year, 2008 8

(24

29b. Signature and title of certifier

mc 32 Registrar's Signature

30. Name and address of person who completed cause death (Item 23a) (Type, Print)

6701

29c. License number

29d. Date signed (Month, Day, Year)

charles St. folts. MJ 2,204

08-05421	
Robin E. Jones	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

23152 2008

		1- For State Cer	tificate of	Death			Re	eg. No.				
Physici	an/	Decedent's Name (First, Middle,Last)					2. Date of Deat	h	3. Time of Death			
al Exam	iner	Robin E. Jones					Month July 15, 20	Day Year 008	0228 hrs			
		4a. Facility Name (if not institution, give street and number)	4	b. City, Town	, or Location	of Death		4c. County of D	Peath			
		Bon Secours Hospital		Baltimore	9				N/A			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia	ast birthday)	If Under 1	rear If Und	ler 24Hrs	. 8. Date of Bir). Birthplace (State or			
Director		215-04-4421 1 M 2XF	33 Yrs.	Months [Days Hour	s Min	March	10 1974	oreign CountryMaryland			
		Usual Residence of Decedent	113.				- Indi Cii	10, 15/9	77 lai y raila			
any			Town or Location	on		-			10d. Inside City Limits			
		Md. Baltimore			Tows	00			1 Yes 2 No			
Aaryland 28a-f show I at once	tor	Md. Baltimore		406 75- 0-4		UII	14	0 - 000				
Mar r 28g	Director			10f. Zip Cod			[]'	0g. Citizen of What				
ith the M 23a or 2	Ω	2 Lacosta Court			212	.04		ι	JSA			
15-0036 filed within 72 hours after death with the Maryland I Hygiene. do other than "natural", or items 23a or 28a-f she t, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U. 1 Never Married 2 Married Armed Forces?		s Decedent of es, specify Cu			ecify Yes or No	- 14. Race - A White, e	American Indian, Black,			
deat or ite	E.	1 Never Married 2 X Married 1 Yes 2 X No		cs, specify od	Dari, Nicalca	ii, i deite	Trican, c.c.,	Wille, e				
after al",	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2X	No specify	<i>r</i> :		Specify:	White			
hours a		15. Decedent's Education (Specify only highest grade completed)	16a. Decedent					16b. Kind of Busin	ess/Industry			
72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	duning me	ost of working	sile. DO NO	useren	reu)					
03(ithin r tha	ш	2			Homema	ker		0wr	n Home			
5-0036 led within 72 Hygiene. other than the Medical	Ö	17. Father's Name (First, Middle, Last)			18.Mothe	er's Name	(First, Middle, I	Maiden Surname)				
21215-0036 uld be filed within 5 Mental Hygiene. marked other that c event, the Medics	Be	Donald McCreadie				C	arol S	cheppler				
21 ould 3 Me s mai	O Service Tours A James In Allegand 10 James to County Tours Many Jan 2100											
AD 2 sh 27 is 1 mat												
e, e, l and l and Healt item			Place of Disposi		cemetery,		Date	20c. Location - Ci	ty or Town, State			
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ti. Pa timer timer		4 Donation 5 Totaler Specify.			•	1		-	_			
Baltimore, MI permit. Pages 1 and 2 s Department of Health a. Important: If item 27 injury or other traum.	. '	21. Signature of Funeral Servi icensee	22. N	same and Add	ress of Facili	™ Ruc	k lowso	n Funeral	Home, Inc.			
		mohant point						aryland 2				
Physician Medical		23a. Part I. Enter the disease. complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one case on each line.										
_xaminer	Immediate Cause (Final disease a. Narcotic (heroin) intoxication											
	or condition resulting in death) Due to (or as a consequence of):											
	<u>_</u>	Sequentially list conditions,	f).									
	i	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C.										
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	f):									
cuted		d			000	-	w 1934 _					
760, icate be executed physician and the burial - transit	ledical	X UNPENDED #23a,PI	1,27,28	Ba-f, p	erME.	G88	1 7/29/0	08 TT				
8760, tificate be ng physic	Mec	IF FEMALE: 23c. If yes, outcome of pregi	nancy					23d. Date of de	livery			
587 rtific ling p	an/M	23b. Was decedent pregnant in the past 12 months?	2 Fet	tal death	3 Ectop	ic pregna	ancy	Month	Day Year			
Box 68 death certi the attendin	sici	1 Yes 2 No 9 of Heknown	ath 5 Oth	ner (Specify)								
Be der	Physicia											
P.O. s that the gned by e detach	by P	Part II. Other significant conditions contributing to death but not re	sulting in the u	inderlying cau	se given in F	Part I.			ite to the cause of death?			
s, P.C ires that signed t	pq F	Cocaine use					1 Yes	3 2 No 3	Probably 4 V Unknown			
Records, The law require	Completed						24a. Was autop		re autopsy findings available or to completion of cause of			
e law e has ge 2 s	ᇤ						perfo	rmed? dea	ith?			
Vital Rec ysician: The l his certificate l director, page		25. Was case referred to medical		00 D	ace of Death	(Observe	1 Yes	2 No 1 V	Yes 2 No			
ital ician s cert recto	Be	examiner?	5D/0 : /: /		Other	`		5 :				
F Vi Physi er this	ို	1 Yes 2 No					ng Home 5		Other:			
J of Jing Ph	ü	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Ir	,,	Injury at Wor	-	_	how injury occurred				
ttenc death death y the	atie	Pending 7/15/08 Accident 5 Pending Investigation	0149 hr	rs. 1	Yes 2X	_ No	unk					
Division of Vital ral or Attending Physician: rs after death al Director: After this certiced in by the funeral directon	ertification:	3 Suicide 6 X Could not be 28e. Place of Injury - At ho	me, farm, stree	et, factory, offic	ce building, e	etc.	28f. Location (Street and Number	or Rural Route Number, City k. N. Carrol			
Divi	Cert	4 Homicide determined (Specify)sidewalk	:				ve. Ba	ltimore,	MD			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only)										
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination at and manner stated.	nd/or investigati	ion, in my opir	nion, death o	ccurred a	at the time, date	and place, and due	to the cause(s)			
F B F 8	Me	29b. Signature and title of certifier		29c. Lic	ense numbe	r		29d. Date signed	(Month, Day, Year)			
		10/11/11/11/11		0.	C.M.E.			July 15, 2008	3			
<		30. Name and address of person who completed source of death (flow	220)									
1		30. Name and address of person who completed cause of death (Item Zabiullah Ali, M.D. Assistant Medical Examiner		n Street, B	altimore	MD 21	201					
7		31. Date filed (Month, Day, Year) 32. Resistrar's Signatu										
S	tate	31. Date filed (Month, Day, Year)	TT. CHA									

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Registrar

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Reg. No.Z U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 08:40AM TU14 2008 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BURNIE Battimore Washington Medical Center 5. Social Security Number 18. Sex 7. Age (In yrs. last birth Arundel ANNE FILEN If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Y March 03 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 ☑ F 218-14-5238 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ☑ No notified Director Maryland | Anne Arundel Millersville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō traumatic event, the Medical Examiner must be 304 W. Pasadena Road 21108 USA or items 23a Funeral 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married aryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify: þ filed within 72 hours : Hygiene. 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Henry Kinder Hilda <u>Yonkee</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 Bernard G. Kalb Sr. (spouse) 304 W. Pasadena Road, Millersville, MD 21108 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State injury or -21-08 4 ☐ Donation 5 ☐ Other (Spe Glen Haven Cemetery Glen Burnie, Marvland 21. Signatur of Funeral Service 22. Name and Address of Facility Stallings Funeral Home, P.A. in y 3111 Mountain Road, Pasadena, MD 21122 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as \ consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 menths? 1 ☐ Yes 2 DANo Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ You 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an certificate has autonsy perform 1 Condia 1 Yes 25. Was case e rred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Properties Funeral Director: the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 31. Date filed (Month, Day, Year) State 18 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death J_{u1y}^{Month} ^{Day}2008 **Physician** 12, 10:03 P M Ilene D. Kwolek /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01nev Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. April 11, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1932 Pennsylvania Director 76 163-26-0344 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Modical Exercity or rust be notified at Director 1 ☐ Yes 2 ☑ No Missouri St. Louis St. Louis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 63128 U.S.A. 140 Worthington Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status within 72 hours after 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White <u>۾</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Company Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Duvall Bertha Myers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is r any injury or other traur 18036 Cottage Garden Dr. #303 Germantown, MD 20874 James L. Kwolek (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Greens Burgy Cathybilc 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 7/17/08 4 □ Donatine Greensburg, PA Cemetery 21. Signar re of Funeral Service Lice ee 22. Name and Address of Facility
Bacha Funeral Home 516 Station St., Greensburg, PA 15601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** arkiovancular /Medical Due to (or as a consequence of) Cancer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of and burialattending physician for use as the buria P.O. Box 68760 The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed nene 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has autopsy certificate 2 100 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ N 1 Dipatient 2 ER/Outpatient 3 DOA Certification: To this After this funeral of 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death | Director: A in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the land 29c. License number 29b. Signature and http of certifier 29d. Date signed (Month, Day, Year) anuer D65292 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Villanvera, MD 18101 Prince Philip Dr., Olney, MD 20832 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:30 A M **Physician** King Juli 2008 Arabella Bessie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Keswick Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days Months 1 ☐ M 2 🖵 F Yrs. 05 21 MD 26 82 217-22-5255 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No Director Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 U.S.A. 2811 Chelsea Terrace Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ∏Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🎇 ☐ No Specify: Black ģ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) I.R.S. <u>Audit Specialist</u> 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Louise Evans ဥ Frederick Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chelsea Terrace, Baltimore, Md 21216 Andrietta King-Daughter 2811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 7/17/08 Arbutus, Md Arbutus Memorial 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 21215 Hom OSON 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ears End-Stage demention disease or condition resulting in death) ue to (or as a nsequence of) Lenny Bridly disea rears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown Month Vear Day 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

death with the Maryland

the burial-transit and attending physician as has page 2 director.

The law requires that the death certificate be executed

To the Hospital or Attending

death.

filled in by

Division or Vital Records, P.O. Box 68760,

After this the

Physician/Medical þ Completed Be Certification: To

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

24 hours after death Prineral Director: Medical completely within 2 29b. Signature and title of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 013657 29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7000. 40 th STREET, BALTIMORE, STO 21211 EREGE, 7000 B. Registrar's Signature M. ISABELLE V/ne 31. Date filed (Month, Day Year)

State Registrar

		For State	State of M	-	epartment of I		lental Hygi	ene	23157
***		Registrar			Certificate of	Death		2008	
Physicia /Medic		Decedent's Name (First, Middle, Paul	Last)	Kible	r		2. Date of Death Month July 16	Day Year 2008	3. Time of Death 5:39PM M
Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of Death	,	4c. County of Death	
~		Dove House				tminster		Carrol:	
Funeral Director		5. Social Security Number 217-03-4131	6. Sex 7. Ag 1 💢 M 2 🗆 F	ge (In yrs. last birth 93	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 28,	Year) Cour	place (State or Foreign ntry) VA
p >		Usual Residence of Decedent		140. Oh. T.					0d. Inside City Limits
aryla shov	_	10a. State 10b. County		10c. City, Town				'	1 ☐ Yes 2√∑ No
ne M 8a-f	Director		imore	R	eisterstown	1			
vith ti		10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cour	itry?
ath v	Funeral	1120 Westminst				1136		USA	
er de	Ĕ.	11. Marital Status	12. Was Decedent Armed Forces?	?	Was Decedent of If Yes, specify Cub	dispanic Origin? (Spean, Mexican, Puerto	əcify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
s aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	ed 1 ∑Yes 2 ☐ If Yes, Give Year or Dates:	NO	1 ☐ Yes 2 🕱 No	Specify:		Specify:	
houn		15. Decedent's		16a. [Decedent's Usual Occu	nation	1.10	W J 3b. Kind of Business/In	nite
in 72	Completed	(Specify only highest	grade completed)	(Give kind of work done life. DO NOT use retire	during most of worki	ng	DE. TAING OF EAGINGOOM	2001. 9
with jiene	E	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Carpenter	·		Construct	tion
2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland is marked other than "natural"; or items 23a or 28a-f show raumatic event, the Medical Examinar must be notified at	BeC	17. Father's Name (First, Middle, La	ast)		*	18. Mother's Name	(First, Middle, Ma	aiden Surname)	
ld be lenta ked ic ev	To B	David Kibler				Carrie	Ruffner		
shou ind M	-	19a. Informant's Name/Relationshi	ip (Type. Print)	19b. I	Mailing Address (Street			City or Town, State, Zip	Code)
5 5 ± 5 €		Phillip Kibler	Son	1	120 Westmir	nster Road	, Reiste	rstown, MD	21136
s 1 a f Hear item other		20a. Method of Disposition			Disposition (Name of crematory or other pla			Oc. Location - City or To	wn, State
Pages nent of int: If its		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		l .	Chapel Cen	i	9/08	Luray, VA	
permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		21. Signature of Funeral Service Li		Dean S	22. Name and Addre			Reistersto	own Road
B a m B B B		Jean A	Phung		Eline Fune	eral Home		erstown, M	
		23a. P rt 1. Enter the disease, or c	complications that cause	d the death. Do no	'. ot enter the mode of dyi	ng, such as cardiac			Approximate Interval Between
Physician	1	lock, or heart failure. List of	inly one cause on each li	INE.	evation	Manage	dial 1	in leave train	Onset and Death
/Medical		sease or condition resulting in death)	a	a consequence of	evation	The Jocan	. 1000-0		
Examiner				(an	levium	path			
F =	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):		J		
sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С						
e be execute sician and burial-transi		resulting in death) Last	Due to (or as	a consequence of):				
ate b hysic he bu	lical		d						
eath certificate attending physi	Physician/Medic	IF FEMALE:							
ath co	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death				23d. Date of delive	
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Luckert Month Year **Physician** Chris 1310 PM JUL 14 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours 1**火** M 2 □ F 216-52-0756 Director 55 March 29,1953 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Edgemere Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21219 4619 Sandwood Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Transportation 12 years Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christopher A. Luckert Audris K. Shiflet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4619 Sandwood Road, Edgemere, Maryland Daughter Alisha Swiger 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 17, 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory Baltimore City, MD. 4 Donation 5 Other (Specify) 2008 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician rebra /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 🗌 No detached the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> pe 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hours after death.

Ineral Director: After this certificate has i autopsy nerformed? 2 X No 1 T Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 🗆 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident filled in by the Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 To the Hospital or within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) vow, MD R25-000 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laura Burton, Mo 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Jacqueline Τ. Lamp July 15 2008 12:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson
nder 1 Year | If Under 24 Hrs. | If Under 8. Date of Birth (Month, Day, Year) Nov.14,1946 9. Birthplace (State or Foreign Country)
New Jersey Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 □ F Months Days Hours Yrs 144-36-9085 61 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 422 Chumleigh Road 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 2 White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Principal -Loch Raven High School Education 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental William Tribus Freda Rosnick ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trau once. Timothy L. Lamp / Husband 422 Chumleigh Road Baltimore, Md. 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 7/21/08 Dunmore, Pa. 4 Donation 5 DOther (Specify) Dunmore Cemetery 21. Signature / Funer I Service Licenses 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 cens Approximate Interval Between Onset and Death 23a. Part1. Enter the disease of shock, or heart failure. List e or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause of each line. Immediate Cause (Final OVARIAN **Physician** months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury iner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Exami that initiated events resulting in death) Last Due to (or as a consequence of): or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes ₽☐No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 217 No 2 ER/Outpatient 3 DOA 2 neral Director: After this filled in by the funeral di Date of Injury

Day Year) After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After Natural Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide PCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

elano, m

DHMH 17 Rev 1/2001

29c. License number

Charles ST

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DHMH 17 Rev 1/2001 **OCME 2006**

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2:30 PMM Isaltina Da Cruz Mattos July 12, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mariner Health Care at Bethesda Montgomery Bethesda If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 M F Months 95 11/10/1912 Director **Brazil** UNINCHN) Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Evaminer must be notified at 1 ☐Yes 2 No **Funeral Director** Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20814-United States 5721 Grosvenor Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 XYes 2 No Specify: Specify: Completed by BRAZILIAN 3 Widowed 4 Divorced **Black** 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Food Preparation Elementary/Secondary (0-12) College (1-4or 5+) Cook 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Unknown) (Unknown) ၉ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa C. Banks/God Daughter 13258 Wonderland Way Germantown, MD 20874item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of H Important: If ite any Injury or ot once. Jul 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland Gate of Heaven 2008 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 21. Signature of Funeral M00382 Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910mann 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) curcularvulo /Medical Due to for as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate of Vital 1 ☐ Yes 2 ☐ No 1 □ Yes 2 1 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Division 5 ☐ Pending investigation s after dec. 1 🗀 Yes 2 🗌 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar (Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

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Year)

2008

a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2 To the 1

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29c. License number

29d, Date signed (Month, Day, Year)

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and manner stated.

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2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 35.57 PM Gregory D. Milhouse 0 ZOCK /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital of Baltimore Baltimore City | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day Year) | North | No 7. Age (In yrs. last birthday) 5. Social Security Number unk 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Country) unk 54 Vrs Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10h. County 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, Ite Medical Examinar must be notified at 1,□Yes 2□No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 n. paca Street 21201 USA Funeral unk Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1∐Yes 2∏ No Specify: Completed by Specify: black Baltimore, Maryland 21215-003 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 12 should be filed with and Mental Hygie 7 is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be Pages 1 and 2 should 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 2401 W. Belvedere Avenue Baltimore, MD 21215 Sinai Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5型Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service
Anthony DP1easant 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death 12 Ca Immediate Cause (Final Psend **Physician** omen brayou disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner lostridium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) the detached 9 Unknown ed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signe should be d Completed by eart 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has S autopsy page performe Mackeremia 2 NO 2 No 1 TYes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending 1 ☐Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: / 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritively Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an tifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jan Friz, TD Singi Hosa tn D egistrar's Signature 31. Date filed (Month, Day, Year) 32. 18 2008 Registrar

KNOWYGS

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Division of Vital Records,

Mathew James Mohr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2008 23163

Physician Examiner 1.0 Deceder's Name (First, Midde, Last) James Mohr Marthew James Mohr Muly 15, 2008 Mohr Muly 2, 2008				r- For S Registr	ar				erunca	10 01			2	Date of Death			3. T	ime of Death	
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VI Pamela E. Southall, MD Assistant Medical Examined 1717 State 3500, 2018-1019		. (30			completed c	ause of de	ath (Item 2	ამ) iner	111 Penn 5	Street Ba	altimore.	MD 2120	11				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3:46 P M July 8, 2008 Tommie Miller 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3800 Enfield Chase Court #114 Bowie Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 26, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days Hours Min. **¼** M 2□ F 78 Yrs 1929 Texas Aug. 467-40-0632 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 📉 No Prince George's Bowie Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20176 U.S.A. 3800 Enfield Chase Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 2 No1948 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🗓 No Specify: 3X Widowed 4 □ Divorced 1975 Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Military 12 Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edmonia Stewart Boage Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leila Davis (Daughter) 5787 Anna Ct., Fontana, CA 92336 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Solon Cemetery Middleburg, VA 7/12/08 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Liconsee 22. Name and Address of Facility Royston Funeral Home 102 E. Washington St., Middleburg, VA 20117 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Congestive heart RATS disease or condition resulting in death) Due to (or all a consequence of): ears Cardiac amyloidusis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of PAIS Atria tibrillation Due to (or as a consequence of): oronar PELTS 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an performed? 1 ☐ Yes 2 🖾 No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

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28a-f show

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

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permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau

Baltimore, Maryland 21215-0036

physician and s the burial-trans attending p signed by the a s certificate has b lirector, page 2 sl director, After

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Completed Be Certification: To

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 7 State 25. Was case referred to medical examiner? 1 ☐ Yes 2 X No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 5 Pending investigation 1X Natural 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Ave NW; Ward 74. Washington DC 20307

0101242467

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgia

and manner stated.

6900 Mary M.D. KWOKI 31. Date filed (Month, Day, Year)

1 8 2008

2. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JUL 7:35 PM MCGEE 2003 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 1 X M 2 - F 214-80-5720 39 20 68 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits

10f. Zip-Code

1 ☐ Yes 2 ▼ No

16a. Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place)

21215

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

Ida Gamble

5103 Levindale Road, Baltimore, Md

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

(Give kind of work done during most of working life. DO NOT use retired)

Home Improvement

Baltimore

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

College (1-4 or 5+)

X□ Yes 2□ No

21215

10g. Citizen of What Country?

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

16b. Kind of Business/Industry

20c. Location - City or Town, State

600 North Wolfe St, Baltimore, MD, 21287

U.S.A.

14. Race - American Indian, Black, White, etc.

Self Employed

Black

Pages 1 and 2 should be filed within 72 hours after death with the Maryland 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral

Director

ERIC

10a. State

MD 10e. Street and Number

11. Marital Status

NA

15. Decedent's Education

(Specify only highest grade completed)

5103 Levindale Road

1 Never Married 2 Married

3 - Widowed Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Thomas J. McGee

19a. Informant's Name/Relationship (Type. Print)

<u>Ida McKay-Mother</u>

12th grade

20a. Method of Disposition

Director

Funeral

þ

Completed

Be

ည

Physician /Medical Examiner

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and attending physician Completed by Physician/Medical ate has been signed by the attending physic page 2 should be detached for use as the I certificate has funeral director, Be မ To the Funeral Director: After this Medical Certification: hours after death completely filled in by the

Division of Vital Records, P.O. Box 68760,

1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		rial Park 7/1	.7/08 Woodlawn,	Md
21. Si nature of Funeral Service Licen	22. Nan Marc	ne and Address of Facility.	Baltimore, Md	21215
shock, or heart failure. List only o	olications that caused the death. Do not enter the			Approximate Interval Between Onset and Death
Immedian Cause (Final disease or condition resulting in death)	a. LYMPHCMA Due to (or as a consequence of):			Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HIV Due to (or as a consequence of): c. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐ Yes 2 ☐ No 9 ☐ Unknown		pic pregnancy or (specify)	23d. Date of de Month	livery Day Year
Part II. Other significant conditions o	ontributing to death but not resulting in the underl	ying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?
			autopsy prior to performed? death?	utopsy findings available completion of cause of
25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)	
1 🗆 Yes 2 🔀 No	Hospital: 1X Inpatient 2 ER/Outpatient 3	□ DOA Other: 4 □ Nursing Ho	ome 5 Residence 6 Other (Spe	cify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred .	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street and Number or R City or Town, State)	ural Route Number,
	ysician: To the best of my knowledge, death occuniner: On the basis of examination and/or investig and manner stated.			
29b. Signature and title of certifier		29c. License number	29d. Date signed (Mont	h, Day, Year)
> YMBM	Mamo	RES-000	JULY 15,	2008

DHMH 17 Rev 1/2001

State Registrar

within 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOWMAN

A Registrar's Signature

				Please	e Type or P					_		Legib	le.		
			1 - For State Registrar		State of N	/laryland		artment of tificate of	Health and I	Mental Hy	/giene Reg. No.	20	0.0	2.2	100
			1. Decedent's Name	e (First, Middle, La	st)			inoute or	Douth	2. Date of De	eath		U-0-	3. Time of I	Death
	Physicia		Jonas				Mo	aciuna	S	Month	15 Day	20	008	5:4	5A M
	/Medio			f not institution, give	e street and number)		4b. City, Town,	or Location of Death	1		County of	Death		
			The Johns	•				Baltimor							
	Funeral	101 00 0100 WM 2 F CO Vrs WM 2 T 17											Counti	^{ace (State or y)} nuania	Foreign
	Director		Usual Residence of			03				July	1./, 1:	938	L U	lualita	
rylanc	at at	_	10a. State	10b. County		,	, Town or Lo						10	0d. Inside Cit	•
не Ма	8a-f	Director	Va.	Frederi	i ck	Cr	oss Ju	nction						1 🗌 Yes	-X NO
with ti	a or 2		10e. Street and Nur	_{mber} akeview [) wi vo			10f. Zip-Code 226	525		10g. Citiz	en of Wh	usa Count	ry?	
leath	must	Funeral	1107 L	akeview L	12. Was Deceder		3. 13. V		Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No	D- 1	4. Race -	America		
after o	or iter			ied 2 X Married	Armed Forces 1 X Yes 2 [If Yes, Give	s? □ No		f Yes, specify Cul I □ Yes 2[v] No		o Rican, etc.)			White, e		
Sours	Fxan	d by	3 Widowed		Year or Dates:							Specify:		nite	
72 h	"natu dical	lete	(Spec	15. Decedent's Ed cify only highest gra			(Give	dent's Usual Occi kind of work doni DO NOT use retire	e during most of wo	rking	16b. Kir	nd of Busi	iness/Inc	lustry	
withir A	than the Me	Completed	Elementary/Seco	ondary (0-12)	College (1-4 o 5+	r 5+)		1 Engine			Eng	ginee	ering	g	
filed	Hygi other ent, ti	Be C	17. Father's Name						18. Mother's Na)		
uld be fil	Menta rrked tic ev	TO B	Visval	das Maci	iunas				Banu	te Gri	gaiti	S 			
2 sho	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na			C -			et and Number or Ri		-				
and	tealth		Mrs. Marj 20a Method of Disp		iunas/ wi				ew Dr. Cro	Date		ation - C			
oges 2	or its		1 🗌 Burial 2	Cremation 3	Removal from State			sition (Name of natory or other pl					•		
Dallillor Dermit. Pages	artme ortant Injury		21. Signature of Fu	5 Other (Specifing Ineral Service Licen	• • • • • • • • • • • • • • • • • • • •	<u> nii</u>	22 22	ervice (ress of Facility			wson,	, Mu	•	
per per	g a T S		1	U-	12X			Ruck To	ress of Facility Owson Fund ork Rd. To	eral Hor owson N	ne, II	nc. 1204			
			23a. Part 1. Enter the shock, or hear	he disease, ir com	plications that causone cause on each	ed the death line.	. Do not ente	er the mode of dy	ying, such as cardia	c or respiratory	arrest,			Approximate Interval Bety	veen
	ysician		Immediate Cause (disease or conditio	Final	a Chron	ic My	elomo	phocut	ic Louker	nia				Onset and D	eath
	Medical aminer		resulting in death)		Due to (or a	is a conseq	ence of):	1	ic Louker tic Levi						
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execu	ian and urial-transit		that initiated events resulting in death) I	S	Due to (or a	is a consequ	ence of):								
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artifica	is been signed by the attending physici 2 should be detached for use as the b	hysician/Medic	IF FEMALE:		One Marine curteen	o of program	201	-							
ath o	for us	cian	23b. Was decedent in the past 12	months?	23c. If yes, outcom 1 Live birth 4 Pregnant	2 🗌 Fetal	death 3	Ectopic pregnar Other (specify)	ncy		2	3d. Date Mont		*	/ear
he de	the a	hysi	1 Yes 2 Dunknown		9 Unknown		, dan 0 _								
that	ed by	by P	Part II. Other signif	ficant conditions of	contributing to death	but not res	ulting in the u	underlying cause	given in Part I.	23e. Did	tobacco u	se contrib	oute to th	ne cause of d	eath?
equires	n sign									1 🗆	Yes 2	¶No 3	Prob	abiy 4 □ U	Inknown
aw re	s bee 2 sho	Completed								24a. Was	psy	24b. W	ere autorior to cor	osy findings a mpletion of c	available ause of
The T	certificate has irector, page 2	Con								1 🗆 Yes	ormed? 2 X No		ath?	2 🗀 No	
VILC Iclan:	ertific ector,	Be	25. Was case referrexaminer?	,	Hospital:			0	26. Place of Dea						
Phys	this c	은	1 ☐ Yes 2 X 27. Manner of Deat		28a. Date of Ir	ijury	ER/Outpatien 28b. Time o	f 28c. Ini	ury at	lome 5 ☐ Res 28d. Describe)	
ding.	th. : After e fune	ation	1 X Natural 2 Accident	5 Pending investigation	(Month, E	Day Year)	Injury		orḱ? ⊡Yes 2.⊡No						
Atter	ector.	ertification:	3 Suicide 4 Homicide	6 Could not b determined	ZDE. Flace OF	njury - At ho etc. (Specify		eet, factory, office	•	28f. Location City or To	(Street and	d Numbe	r or Rura	l Route Num	ber,
<u>a</u> 2	al Dir	Cer													
DIVISION OF VICE INCOMES, I.O. DOX 00/00, To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (check only one)		nysician: To the bes miner: On the basis and manner	of examinat									3)
o the	ithin 2 orthe	Med	29b. Signature and	I title of certifier	And manner	Stateu.		29c. Licer	nse number		29d. Date	e signed ((Month, L	Day, Year)	
ř	≠ F Ö		1 B	1 APoi	MD			RE	S-00C)	July	115	, 26	308	
	11		30. Name and addi	ress of person who	completed cause of	of death (Item	1 23a) (Type,								
10			Barba	ava Hell	MD Boois	trar's Ci	110		600	North W	olfe S	, Bali	imor	e, MD,	21287
	Sta Registr		31. Date filed (Mon	L 1 8 2008	8 Algoria	ital s Signat	ure	W							
				Apa											

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day \mathbf{P}^{M} 2008 3:00 July Pearl Moore 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 6309 Magdolena Road Baltimore Rosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 X F 97 05/16/1911 North Carolina 242-01-9933 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 25 No Maryland Baltimore Rosedale 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 U.S.A. 6309 Magdolena Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2001No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes → No Specify: Specify: ģ White 3XXVidowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physician's Office Nurse 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emmaline McDaniel Julius Hampton Toney 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6309 Magdolena Road, Baltimore, Maryland 21237 Puala Hepner (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gard: 07/17/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A.
1407 old Eastern Avenue, Essex, Maryland 21221 21 Signature of Euneral Service Leensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Act was a consequence of:

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-trans and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical 23c. If ves. outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 110 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) Type. Print)

LIXA DFC FERIND 0 118 Risce & BAHO 2123 Registrar's Signature PF 6 -31. Date filed (Month, Day, Year) 2008 State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

08-05461
Andrew Neubauer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008	23168
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		1- For State Registrar		Certific	cate of	Death		Re	eg. No.		0 20.0
Physici Medical Exam		Decedent's Name (First, Midd	le,Last) Edward N	eubauer				2. Date of Dear Month July 16, 20	th Day Ye		3. Time of Death 0916 hrs
		4a. Facility Name (if not institution Northwest Regional H	on, give street and nu		4	b. City, Town, or Lo Randallstown			4c. County Baltimo		nty
Funeral		Social Security Number	6. Sex	7. Age (In yrs, last b	irthday)	If Under 1 Year	If Under 24Hrs	8. Date of Bir	th(MM/DD/YYY	y 9. Birtl	nplace (State or
Director		216-35-3599	1XM 2F	16	Yrs.	Months Days	Hours Min.	03/02	/1992	Foreign Cou	n Intry) MD
×		Usual Residence of Decedent		Tra au =						1	10d. Inside City Limits
ow an		10a. State 10b. County		10c. City, Tow		_					1 Yes 2 X No
rykand a-f show t once.	ctor	MD Ba	1timore			Reisters 10f. Zip Code	town	1	0g. Citizen of W	hat Coun	71
or 28	Director	308 Sacred H	eart Iane				136	ľ	USA		.,,
72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho at Examiner must be notified at once.		11. Marital Status	12. Was Dec	edent Ever in U.S.		Decedent of Hispa	anic Origin? (Sp		- 14. Rac	e - Americ	ean Indian, Black,
death or iter	Funeral		larried Armed Fo	2 X No		es, specify Cuban, I		Rican, etc.)	Whit	e, etc.	
hours after "natural", Examiner	by		orced If Yes, Give Year or Dates:			Yes 2 X No			Specify:		hite
2 hour "natu	Completed	 Decedent's Education (Spe Elementary/Secondary (0-12) 				's Usual Occupationst of working life. I			16b. Kind of B	usiness/ir	ndustry
336 thin 7 ne. than edical	nple	10	35.1095 (1	,		Student			High	n Sch	1001
215-0036 be filed within ntal Hygiene. rked other tha ent, the Medic		17. Father's Name (First, Middle	, Last)	<u></u>			3.Mother's Name	(First, Middle, I	Maiden Surname		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Edward G. Neubauer Cecilia A. Frederic										
	Cecilia A. Frederick Mother 308 Sacred Heart Lane, Reisterstown, M										Zip Code) 21136
Baltimore, bermit: Pages I ar Department of Hee Important: If the	1 X Burial 2 Cremation 3 Removal from State Crematory or other place) New Cathedral Cemetery 7/21/08 Baltimo									imor	e.MD
Baltimo permit: Page Department o Important: injury or oth	- 1	4 Donation 5 Other S 21. Signature of Funeral Service) //		ame and Address of			Reister		
E P P E		Stephen	- m-4	entsin		ne Funer		Reist	erstown	, MD	21136
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause		used the death. Do	not enter th	e mode of dying, s	uch as cardiac o	r respiratory arr	est, shock, or he	eart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)		ary hemor	rhage	of uncle	ear etio	logy_			Death
			b.	consequence of):							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		consequence of):						-	
	Examiner	(Disease or injury that initiated events resulting in death) Last	С	consequence of):							
18760, rtificate be executed ing physician and as the burial - transit			d			V7 (0 100 mm			
8760, ifficate be executed ng physician and ss the burial - transi	n/Medical	X UNPENDED	AMENDED	23a,27,28	a-1,	perME, go	384 10/2	9/08 11			
8760, tificate being physic as the bur	J/M	IF FEMALE: 23b. Was decedent pregnant in the		outcome of pregnand wirth	у Гот	al death 3	Ectopic pregna	IDCV	23d. Date of Month		ay Year
Box 68 e death certi the attendin ed for use a	icial	past 12 months?	4 Pregn	ant at time of death		er (Specify)	cotopio pregna	inoy	l lionar		uy rou.
Bo ne deat the at	Physicia		known g Unkno								
tal Records, P.O. Box 6 cinn: The law requires that the death cer certificate has been signed by the attendi ector, page 2 should be detached for use		Part II. Other significant condit	tions contributing to	death but not result	ing in the u	nderlying cause giv	en in Part I.				he cause of death? ably 4 Unknown
ds, l	ted							24a. Was	-		opsy findings available
COTC law re has be	Completed by							autop	sy		ompletion of cause of
Re t The iffcate		25. Was case referred to medica	.1			26 Piggs 6	of Death (Check	1 Yes	2 No	✓ Ye	s 2 No
/ital 'sician is cert	o Be	examiner?	Hoositel.	npatient 2 🗸 ER/	Outpatient		ther:	g Home 5	Residence 6	Other	
Division of Vital Records, tal or Attending Physician; The law requir is after death. al Director: After this certificate has been sited in by the funeral director, page 2 should t		1 ✓ Yes 2 No 27. Manner of Death	28a. Date (Month		. Time of In				how injury occur	red	
ion tendii eath. tor: A	Certification:	1 Natural 5 Pend 2 Accident Inve	diam		d 7:3	0 am ¹ Ye	es 2 X No	unk			
Division pital or Attent ours after death teral Director:	tifica	3 Suicide 6 X Coul	ld not be 28e. Plac	e of Injury - At home, found at	farm, stree	t, factory, office bui	ilding, etc.	28f. Location (Street and Numb	er or Rur acre	al Route Number, City d Heart Ln.
D ospital hours neral y fillec	Cer	4 Homicide	rmined (Specify)					Reister	stown,	MD	
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Medical	(Check only	hysician: To the bes miner:On the basis								
To To com	Mec	29b. Signature and title of certific	and manner s	tated.		29c. License			29d. Date sign		
		Il all	1			0.C.M	I.E.		July 17, 20	800	
		30. Name and address of person	who completed caus	se of death (Item 23a)				_		<u> </u>
		Russell Alexander MD		ledical Examine	r 111	Penn Street, E	Baltimore, M	D 21201			
Si Regis		31. Date filed (Month, Day, Year)		gistrar's Signatur	A second	New York					
Kegis	a tell	0011		Andrea De	-				OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2008 Year 2:35 PMM July 16, Daphne S. Oster /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Center Montgomery Rockville Date of Birth (Month, Day, Year) 01/03/1918 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 90 Months Days Hours Min England 038-20-9001 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Ire Modical Examinar must be redified at Director 1faYes 2 □ No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 299 Hurley Ave. 20850-United Kingdom Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ∏Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify ð Specify: White 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Education Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If frem 27 is marked other the any Injury or other trainmant. Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertram George Brown Lily Jane Tudball ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine E. Ostell/Daughter 128 Calvert Rd. Rockville, MD 20850-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jul 18 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Beltsville, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility Rapp Funeral & Cremation Services M00382 933 Gist Ave. Silver Spring, Maryland 20910-Human 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LLYC /Medical ue to (or as a consequence of): Examiner as a consequence or): Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner requires that the death certificate be execute Exami burial-tran Due to (or as a consequence of): physician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the detached i 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð sign 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate performe 2 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Records, Division of Vital Physician: Hospital or Attending within 24 hours after deatl To the Funeral Director: filled in by the completely the

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

V

State

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101 10

Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Molecular Dr. Rockville, MO

D0062435

2085

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle-Last) 2. Date of Death **Physician** 45 AM ans 5,2008 /Medical Summit Tark Nursing 4b. City, Town, or Location of Death Examiner County of Death Home atonsu: lle ltimore (In yrs. last birthday)
Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day Apr. 13 Funeral or Foreign 1□M 2**X** F Months Days Hours Min. 216-20-610 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show T is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar inust be nutfined at 1 XYes 2 □ No **Funeral Director** timore 10e. Street and Munber 10f. Zip Code 10g. Citizen of What Country? Tressman 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No δ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NΦT use ∎etired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Ite Magnee. College (1-4or 5+) stodian ather's Name (First, Middle, Last) Be ပ wens 19b. Mailing Address (St Number, City or Town, State, Zip Code) Nesth:11s paltimore, on D 21229 Road Baltimore, 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 21.08 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER Physician ancreatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the carrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ь in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed' 1 ☐ Yes 2 No 2 (21No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) : After this ce funeral dire Other: ဥ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 □ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1005694 200 8 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

350 Annon

Registrar's Signature

34 BACTIMEMERICIEN

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1 8 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day HERBERT JOSHUA ROBINSON 6/21/08 2:45AMM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 7121 Park Heights Avenue, #805 Baltimore, MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) 1₹M 2□ F Days Hours 225-30-4702 20/1926 Luray, VA Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7121 Park Heights Avenue, 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2K No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Financial Advisor Private Industry

7121 Park Heights Ave.,

20b. Place of Disposition (Name of cemetery, crematory or other place)
Howard Univisity

18. Mother's Name (First, Middle, Maiden Surname)

22. Name and Address of Facility Austin Royster Funeral Home

AND CHRONIC BRONCHITICIS

24a. Was an autopsy perform

1 □ Yes

Balt., MD 21215

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

Month

23e. Did tobacco use contribute to the cause of death?

1 X es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

1 ☐ Yes

5 Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

15 mos

6/21/08 Washington, DC

Ann Housberg

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Department of Important: If it any Injury or conce. Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

William Robinson

19a. Informant's Name/Relationship (Type. Print)

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Sue Robinson/Wife

4 Donation 5 ☐ Other (Specify)

21. Signatury of Foreign Service Licensee

Funeral

Director

show

the

death 1

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Mark

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burial-transit and attending physician the as for use a the detached signed by 1 I be detach peen page 2 s has certificate this After this funeral of n 24 hours after death.

The Funeral Director: A pletely filled in by the death.

the death certificate be executed

Box 68760.

P.O. I

Records,

Division of Vital

Physiclan:

Hospital or Attending

To the Hosp within 24 hor To the Fune completely fi

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IF FEMALE: 9 Unknown

1 ☐ Yes

1 Natural 2 Accident

3 Suicide

29b. Signature a

4 Homicide

Physician/Medical ð Completed Be Certification: To 27. Manner of Death 29a, Certifier Medical

3821 14th Street, N.W., Washington, DC20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Caus (Final METASTATIC LUNG CANCER disease or condition resulting in death) Due to (or as a consequence of): RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last EMPHYSEMA Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 4 ☐ Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 Other (specify) 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manger as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1 ☐ Yes 2 ☐ No

29d. Date signed (Month Day, Year) 00

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DR. Tou

State Registrar

08-05338 Calvin Walter Ray

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 23172

	- For State Certificate of Death Reg. No.	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Calvin Walter Ray 2. Date of Death Month Day July 12, 2008 3. Time of Death 0409 hrs	
,	4a. Facility Name (if not institution, give street and number) Sinai Hospital 4b. City, Town, or Location of Death Baltimore City 4c. County of Death	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min. Dec. 02, 1990 Foreign Country)	
Maryland 28a-Fshow any 1 at once. ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. N/A Baltimore 1 Yes 2 No.	
the Maryland 3a or 28a-f sh otified at once	3767 Liberty Hts. Are. 21215 10g. Citizen of What Country?	
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2 3 3 6	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16c. Aid 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Business/Industry 16c. Aid 16c. Stores	
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MD 21 d 2 should 1 th and Men n 27 is man numatic ev	19a. Informant's Name/Relationship (Type, Prin) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon D. Brwn - mother 3707 Liberty HB Ave Apt A. Bacto. nd, 21215	
Baltimore, MD 2 sernit. Pages I and 2 shou bepartment of Health and important: If then 27 is r injury or other traumarte	20a. Method of Disposition 1 VBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, 1 Date crematory or other place) KING MEN. Park 7-19-08 Randauls forwn, mi	
	21. Signatur of Funer's Service Locksee 22. Name and Address of Facility 270 Fire d H ILTON Pass Pinarch F. H. Balto, md. 21229 23a. Part Menter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva	al
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Scuted and transit	(Disease or injury that initiated events resulting in death) Last C: Due to (or as a consequence of):	-
ial am	UNPENDED X AMENDED 28b, perME, g881 7/24/08 TT	
). Box 68760, the death certificate by the attending physiched for use as the bun Physician/Met	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown	
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Division of Vital Records, P.O. Box 68'. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as ledical Certification: To Be Completed by Physician	24a. Was an autopsy findings availab prior to completion of cause of performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	le
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Division of ' To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification: T	29a. Certifier (Check only one) 29a. Certifying Physician: 7 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
7	29b. Signature and title of centrier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 12, 2008	
OCME	30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registra	31. Date filed (Month, Day, Year) 32. Registrar's Signature for the signature of the signat	

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with t		10e. Street and Number 6708 Pumple	Marti	n Court			10f. Zip Code	784			•	ISA	untry :
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/Medical		resulting in death)	a.	Due to (or as							~		
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The la	E									autor perfo	ormed? 2 ANo	death?	37
cien: 1	a	25. Was case referred to med	dical					26. Place	e of Death	(Check only o			
yslci yslci is cer direc	To B	examiner? 1 ☐ Yes 2 ☐ X o	Но	ospital:	ient 2 🗌	ER/Outpatier	t 3 DOA Othe	er: 4 X Nu	ursing Hon	ne 5 Resi	dence 6	Other (Spec	cify)
neral		27. Menner of Death 1 XNatural 5 Per	ndina	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of	28c. Injury Work	at	2	8d. Describe	how injury oc	curred	
endir eath. or: Al	atle	2 Accident inv	estigation				M 1 🗆 Y	Yes 2 🗌	No				
OIVISION OI OF Attending Phy after death. Director: After this I in by the funeral of	Certification;		uld not be termined	28e. Place of In building, e	njury - At ho tc. <i>(Specif</i>)	ome, far <i>m</i> , str y)	eet, factory, office		2	28f. Location (City or To	Street and Ni wn, State)	umber or Ru	ıral Route Number,
urs all								70.00					
To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certi (Check only 2 Medi	rying Physical Exemine	er: On the best and manner s	of examina	wiedge, deat tion and/or in	n occurred at the tim vestigation, in <i>m</i> y or	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s)
o the ithin 2 o the omple	Med	29b. Signature and title of cer	tige /			2 - 0 - 0 -	29c. License	number			29d. Date si	gned (Monti	h, Day, Year)
⊢≯≓ŏ			ME		- LH	1751L),	DO DO	006	2704	4	07	01.	2008
(10)		30. Name and address of per	son who con	mpleted cause of	death (Item	1 23a) (Type	Print)		~	,	07	1.0	20012
		- 100	· Ri	dges	2000	y Su	ite 10	70,	E. M	-i Cott	City	(۲)	D 21043
Sta Registi		31. Date filed (Month, Day, You JUL 18	2008	32. Regist	rar's Signa	Span	E)				,		

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Month SEALOVER MARY 20:02 PM 14 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORG JOHNS HOPKINS BAYVIEW MEDICAL CENTER 8. Date of Birth (Month, Day, Year) June 19,1919 If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🛣 F Months Hours 415-18-8061 Director 89 Tennessee Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Edgemere 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 7 7112 Riverdrive Road 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: White ≥ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Hairdresser Cosmetology Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental be Edward Preston Short May Cline 1 and 2 should ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. 7112 Riverdrive Road, Edgemere, Maryland 21222 Preston Sealover son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 16 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore City, MD. 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 nthone 23a. Part 1. Enter the disease or complications that caused the death, shock, or heart failure. Hist only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician SUBDURAL HEMATOMA DUE TO FALL PAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Dia: to (or as a consequence of) n any, leading to immedia cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☑ No Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 CONCESTIVE HEART FAILURG ATMIDE FRANCISTION COUDYNON 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed ASTERY DISCASE HISTORY OF PERIPHERAL STROKE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' (Hashie CLENAL VBSCLUMBON DISEASE 1 □ Yes 1 ☐ Yes 2 ☐ No 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ➡ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 348 28d. Describe how injury occurred Natural 5 Pending 1 hours after death. •uneral Director: A ely filled in by the fu 2 Accident 3 Suicide investigation 1 ☐ Yes 2 ☑ No FALL JULY 12 LOCK 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Burg! Route Number, Rd City or Town, State) 1046 Old Northpoint 4 🗌 Homicide determined FUTURE CARE NUMBER HOME GANTON within 24 hours at To the Funeral D completely filled i 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ZVLY R45-000 2008 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE BALTIMORE CHANLES GALANU M.D HAND ERSTERN 21224 Registrar's Signature 31. Date filed (Month, Day, Year) State 1 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. No. 2008

23174

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 28b, 28e, & 28f, per ME Certificate of Death T Range 2

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:00PM William L. Stewart July 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Thomas More Nursing Home Hyattsville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F Months Days 12,193 Washington, DO 578-48-8435 Feb. Director 70 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location and Mental Hygiene.
is marked other than "natural" or items 23a or 28a-f show
raumatic event, the "sedical Eventing" and to redified at 1 XYes 2 No Director DC Washington, DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3628 Warder Street, N.W. 20010 by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 56-57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ∐Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Landscaper 12 Private Industry 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) Be William H. Stewart Bertha Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aisha T. Stewart/Daughter 1210 Shepherd Street, N.W. Washington, DC 20011 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Nat Cem 7/12/08 Laurel, MD 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Super-3821 14th Street, NW, Washington, DC 20011 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final altuman Immunodeficiency Virus ²hvsician 1-ears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed ourial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) signed by the a d be detached for P.O. I □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 **7** No 2 🗆 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 001852 July 3,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queersbury Rd Hyg Trsville MD 20781

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 18

2008

MO Registrar's Signature

		For State Registrar	State of Maryland / [Department of He Certificate of D		tal Hygien	711118	23176
		Decedent's Name (First, Middle, Last)				Date of Death	ay Year	3. Time of Death
Physicia /Medic		Phoebe Raquel	Sides		Ju			11:10 P ^M
Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or I	Location of Death	4	c. County of Death	
Funeral Director			7. Age (In yrs. last bir	thday) If Under 1 Year Months Days	If Under 24 Hrs. 8, I Hours Min. (Date of Birth Month, Day, Yea	r) Coun	lace (State or Foreign try)
Δ		None Usual Residence of Decedent			30 Ju	1y 6, 20	008 Mar	vland
ryland how		10a. State 10b. County	10c. City, Town	n or Location			1	0d. Inside City Limits
e Mar ha-f si	턍	Maryland Montgome	ry	Kensington				1 ☐ Yes 2 ☑ No
ith th	Director	10e. Street and Number		10f. Zip Code		10g. C	Citizen of What Coun	try?
s 23a		2505 Campbell Pla			895	Uni	ted State	S
1215-0036 within 72 hours after death with the Maryland ene. I than "hatural" or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar	panic Origin? (Specity , Mexican, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
-00 2 hour	edit	15. Decedent's Edu	cation 16a.	Decedent's Usual Occupat		16b.	Kind of Business/Inc	lustry
215 nin 72 na "na Media	Completed	(Specify only highest grad	completed) College (1-4or 5+)	(Give kind of work done du life. DO NOT use retired)	uring most of working			
d with giene ar tha	E O	0	College (1-401 5+)	None			N/A	
al Hy	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name (Fin	st, Middle, Maide	en Surname)	
/lai	ToE	Philip D. Sides,	Jr.		Jennifer	L. Singe	er	
Z sho and is ma auma		19a. Informant's Name/Relationship (Ty	pe. Print) 19b	. Mailing Address (Street a	nd Number or Rural Ro	ute Number, City	v or Town, State, Zip	Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural;" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.		Philip D. Sides, 20a. Method of Disposition 1 □ Burial 2 【© Cremation 3 □ F	20b. Place of	05 Campbell Disposition (Name of ry, crematory or other place	Place, Ken	sington,	Maryland Location - City or To	20895 wn, State
timen tant:		4 □ Donation 5 □ Other (Specify)	rioregone	ry Crematorium,	Im. July 13,	2008 Bet	hesda, Ma	ryland
Bal permii Depar Impor any Ir		21. Signature of Funeral Service Licens	M01532	Robert A. P	ntgomery A	ve.,Rock		rv1and 20850
Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Preterm Birt Due to (or as a consequence	h	, such as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
Examiner tissue	Examiner	Sequentially list conditions, if any, leading to immediate the conditions of the con						
876(sate be the sicial the burn	Completed by Physician/Medical Exa	resulting in death) Last	Due to (or as a consequence	of):				
vision or Vital Records, P.O. Box 68 Atending Physician: The law requires that the death certifica rotesth. ettor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the state of the second state of the second state of the second seco		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ဩNo 9 □ Unknown	Gc. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ery Day Year
rds, P.O. I							id tobacco use contribute to the cause of death? ☐ Yes 2█ No 3☐ Probably 4 ☐Unknown	
Division or Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be death.						24a. Was an autopsy performed? 1□ Yes 2☑↑	prior to con death?	psy findings available impletion of cause of
Vital Fictan: The certificate	Be	25. Was case referred to medical examiner?			26. Place of Death (Cf			
or V	2	1 ☐ Yes 2 █ No	lospital: 1 X Inpatient 2 ☐ ER/Ou	·	4 Inursing Home	5 Residence	6 □Other (Specif	y)
ding Ph After th funeral	Ë	27. Manner of Death 1 ★Natural 5 Pending		Time of 28c. Injury njury Work?		Describe how in	jury occurred	
SiO ttendi leath. tor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be			es 2 □ No			
	Ħ	4 Homicide determined	28e. Place of injury - At home, fa building, etc. (Specify)	rm, street, factory, office		ocation (Street and City or Town, Sta	and Number or Rura ate)	I Route Number,
Hospita Hours Funeral	edical Ce	29a. Certifier (Check only one)	sician: To the best of my knowledge ner: On the basis of examination an	e, death occurred at the time	e, date and place, and inion, death occurred a	due to the cause	(s) and manner as s	tated. o the cause(s)
To the I within 2. To the I complet	Med	29b. Signature and title of dentifier	and manner stated.	29c. License	number	29d F	Date signed (Month,	Dav. Year)
8 7 8 7	-	> PIIIIAN	10			230.		
	-	30. Name and address of person who co	ampleted source of death (Herm 00-)		65569		July 6,	2008
					Do al2 1 1	M 1	_1 20050	
Sta	te	Cynthia King, M.D. 31. Date filed (Month, Day, Year)	, 9901 Medical C	enter Drive,	KOCKVILLE	, Maryla	na 20850	-
Registr	-	JUL 1 8 200	32 Registrar's Signature	book				

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LENORE JULY SORKIN 14 2008 3:20A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN HILL ASSISTED LIVING DAYTON HOWARD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, **Funeral** 1 □ M 2 🛚 F Months Days Hours Min 01/18/1925 NY Director 097-18-6529 83 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or Items 23a or 28a-f sh Examiner must be notified Director 1 ☐ Yes 2 X No MD HOWARD DAYTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14269 TRIADELPHIA MILL ROAD 21036 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No ģ Specify: WHITE Specify 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other th any Injury or other traumatic event, 11% once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ABRAHAM** FINKELSTEIN EVELYN CHANOVITZ ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10382 BARCAN CIRCLE, COLUMBIA, MD 21044 LAWRENCE SORKIN / SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) COLUMBIA MEMORIAL PARK 07/17/2008| COLUMBIA, MD 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cause (Final **Physician** DEMENTIA ADVANCEO 4 EAVS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events continued to the continued of the co Examine Due to (or as a consequence of) law requires that the death certificate be executed ending physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached for □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 □ Yes 2 XNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify ASSISTED Hospital: 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA LIVING 27. Manner of Death 1 Natural Certification: 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certi 29c. License number D5/860 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) # 200 Cownell DN 10700 JOHAMON CHARTER 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 1 8 2008 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM# 7, per FH, G88T, 7/21/08, ws State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HARLES Mon (C) TETTEH 80 0315 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 408 Clairborne Street Upper Marlboro Social Security Number Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Days Year) Months Hours Min 27 80Yrs. 261-42-6430 **Director** Ghana 11 30 27 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1√Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be 5000 Govane Ave 21212 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 Completed by 1 □Yes 🎇 □ No Specify Specify: Black 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4yrs Pressman 12th grade MD Paper Box Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Payne Emmanuel Okyne ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 408 Clairborne Street, Upper Marlboro, Charlene Burton-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Woodlawn 7/19/08 Baltimore Co, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. P rt1. Enter the disease, or complications that caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest s lock, or help failure. List only one cause on a ch line. Approximate Interval Between Onset and Death Immediate Cause (Final neta state **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initirediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine use as the burial-tran Hospital or Attending Physician: The law requires that the death certificate be exe Due to (or as a consequence of) cate has been signed by the ettending physician page 2 should be detached for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 🖪 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Fother (Specify) 1 ☐ Yes 2 X No RESIDER Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Example 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated July 16, 2008 29c. License number 21438 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar MILHAEL

Day

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37 Registrar's Signature

DEFENSE HIGHWAY ANNAPOLIS MOLIYO

		-	1 - State of Maryland / Department Certificate		nentai riygi Re	9. 0 0 2 ол в	23179			
	Physicia	an.	1. Decedent's Name (First, Middle, Last)		Date of Death Month		3. Time of Death			
/Medical			Julius William Thomas		07	17 2008	3:55 AM			
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, To	4c. County of Death						
est to				onium, Maryla		Baltimor				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birti	nplace (State or Foreign untry)			
	Director		220-03-2988 Residence of Decedent		09/25/1	920 Ma	ryland			
	land ow at		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
	Mary i-f sh		MD Harford Joppa				1 □Yes 2 No			
	r 28a	Director	10e. Street and Number 10f. Zip C	Code	10	ng. Citizen of What Co	intry?			
	h with	Funeral D	2409 Gilwood Drive 21	085		U.S.A.				
	deat			ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	ican Indian,			
9	J within 72 hours after death with the Maryland glene. glene. Than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at		1 ☐ Never Married 2 ② Married 1 ☐ Yes 2 ② No		ricali, etc.)	Black, White				
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21215-0036	"nati	Completed by	15. Decedent's Education (Specify only highest grade completed) (Give kind of work life. DO NOT use	done during most of work	ing 1	16b. Kind of Business/I	ndustry			
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d 2	art, E		17. Father's Name (First, Middle, Last)		e (First, Middle, M					
lan	Ø # Ø Ø	To Be	Stephen James Thomas	LTllia	n Elizabe	zabeth Rode				
Maryland	shou and M is mar	ř	-			Noute Number, City or Town, State, Zip Code)				
ž	alth ar 27 is er trau		Angeline M. Thomas (wife) 2409 Gilwo	od Drive - J	Joppa, Ma	rvland 21	085			
J.	ges 1 and 2 should it of Health and Mei If Item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name			20c. Location - City or				
Ē	Pages nent of ant: If its ary or o		1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory	i i	8/2008	Baltimore.	Maryland			
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee 22. Name and	Address of Facility E	F. Lassa	ahn Funeral	Home, P.A.			
<u> </u>	89 5 8 9			Belair Road -						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between			
-	Physician		Immediate Cause (Final disease or condition CONGESTIVE HEART FAILURE							
	/Medical Examiner		resulting in death) Due to (or as a consequence of):							
	LAGITIMET	<u>. </u>	Sequentially list conditions, b.							
Jr	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			-				
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200	e be siciar	E E	d							
68760,	rificate be executed ig physician and as the burial-transit	ledical	0.							
Вох			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	2		23d. Date of del	23d. Date of delivery			
_	000	Physician/N	in the past 12 months? 1		Month	Month Day Year				
P.O.	that the de sed by the detached	چ	9 □ Unknown							
	requires that the peen signed by th hould be detache	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cau		Did tobacco use contribute to the cause of death?					
ord	v requir been s should				1 ☐ Ye	s 2 No 3 Pr	obably X Unknown			
ec	aw Is b	Completed			24a. Was ar autops		topsy findings available completion of cause of			
<u>=</u>	: The lacate hapage (် ပ			perform 1 ☐ Yes 2		2 No			
Vita	siclan: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Out	th (Check only on					
of	S Si P	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA			ence 6 COther (Spe	cify) HOSPICE			
n c	Jing 1 After funer	io	1 XX Natural 5 ☐ Pending (Month, Day, Year) Injury	3c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe ho	w injury occurred				
Sic	Attending r death. sctor: After by the fune	ertification:	3 Suicide 6 Could not be				28f. Location (Street and Number or Rural Route Number,			
\equiv	after after Dire	ertii	4 Homicide determined building, etc. (Specify)	City or Town, State)						
	Hospital 14 hours a Funeral I tely filled	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	_ (1 (1)	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	in my opinion, death occu	rred at the time, d	ate and place, and due	to the cause(s)			
	To the within To the comple	ž	29b. Signature and title of certifier 29c.	License number	2	9d. Date signed (Mont	h, Day, Year)			
) -/- D	43725		7/17/1	8			
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
	6		DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.	TIMONIUM,	MD 2109	3				
	Sta Registr	te ar	31. Date filed (Month, Pay Year) 8 32, Registrar's Senature							

3:55 a.m.

JULY 17, 2008

JULIUS THOMAS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** OREST JULY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner JOHNS HOPKINS BAYNIEW MEDICAL CENTER SALTIMORE if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/22/1926 . Age (In vrs. last birthday Social Security Number 6. Sex Birthpiace (State or Foreign Country) Funeral 1 ☐ M 2 ☐ F Days Hours Min Director 276 22 1961 81 Kentucky Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the lifed at Maryland Baltimore Middle River 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3521 Wagontrain Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify à Specify: white 3 XWidowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) s 1 and 2 should be filed within if Health and Mentat Hygiene. Item 27 Is marked other than College (1-4or 5+) 8 Roller Bethlehem Steel Corp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Traylor Louella Little Vernon ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hope Davidson (daughter) 3521 Wagontrain Road Middle River, Maryland 21220 Pages 1 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Memorial Gard 7/18/08 Baltimore County Maryland 4 ☐ Monation 5 ☐ Other (Specify) of Fundral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Sign 1407 old Eastern Avenue Essex Maryland 21221 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. He Hours Onset and Death Immediate ause (Final disease of condition resulting in death) **Physician** SUBDURAL HEMATOMAS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical 23d. Date of Wery IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant APPROVE TO ME 3 Ectopic pregnancy in the past 12 months? Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No o 9 Unknown ٥ 23ect tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 2 No Vita 2 No 1 ☐ Yes 1 □ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To of Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division Hospital or Attending Injury 1 Natural 5 Pending ours after death. 2 Accident investigation JULY 13, 2008 LUKNOWN M 1 ☐ Yes 2 ☑ No FELL DOWN STATES 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide MIDDLE HOME 3521 WAGON TRAIN RD., RIVER 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number M.D.RES-000 JULY 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LI AVENUE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:25 A 2008 July 15, Ulrich John Η. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) **Examiner** Baltimore Essex Riverview Nursing Center Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Days Min 1X M 2 □ F November 29,1926 81 Raspeburg, MD. 220-12-7671 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2X No Director Baltimore Dundalk Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2628 Plainfield Road 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1ĂÎYes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1∐Yes 2∐XNo Specify: Specify: White 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chervon Supervisor 10 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Lucinda Nichols William George Ulrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2628 Plainfield Road, Dundalk, Maryland Daughter Tina Blair 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition July 23, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD. Garrison Forest VA 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 2/45 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only see cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATRIAL FIBRILLATION disease or condition resulting in death) Due to (or as a consequence of): SICIL SINUS Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner CEREBRO VASCULAR Due to (or as a consequence of): DALNUTRITION IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 DNo 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, attending physician and for use as the burial-tran been signed by the should be detached Division of Vital Records, After this certificate has funeral director, page 2 s this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

Funeral

Director

28a-f show

Department of Health and Mental Hygiene Industrial in the Majora I is marked other than "natural" or items 23a or 28a-f shou any injury or other traumatic event, the Majora Examiner must be notified at once.

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Certification: To

(Check only

29b. Signature and title of certifie

State Registrar

1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

29c. License number

29d. Date signed (Month, Day, Year)

BLANKES Place Drundelle NO 21222

ation t known as Richard Vines Baltimore. Marvland 21215-0036 **Physician**

/Medical

Examiner

Funeral

Director

show

Items 23a or 28a-f shiner must be notified

Director

death with the Maryland

Completed by Funeral "natural", or Iten edical Examiner ould be filed within 72 hours after Mental Hygiene. th and Mental Hygiene.
It is marked other than "nature traumatic event, the Medical Baltimore, Maryland Be ပ item 27 i Department of himportant: If ite any injury or ot once. Physician /Medical Examiner Examiner law requires that the death certificate be executed and burial-tra P.O. Box 68760, physician s the buria Completed by Physician/Medical as ding nse atter ō signed by the a d be detached for or Vital Records, cate has I certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Medical Certification: To State Registrar

amend sitems Maryland Debaraterill 1888 and Merkal Hygiene

1- For Amend item 23e per phys. g883 Certificate of Death

Reg. No. Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Charo 14:25 M JULY 2008 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death of Baltimore city Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Yrs. Social Security Number Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 6. Sex 18-961 1 M 2□F Months Days Hours Min Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No HIMOre Street and Number 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) thlehem Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, ∞ h Kollina Va. Wood 20b. Place of Disposition (Name of cemetery, crematery or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 D Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Funera eene 5151 Balti More National 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. List only one cause on each line. Immediate Cause (Final Leiomyosarcoma disease or condition resulting in death) 12 hours Due to (or as a consequence of) Diverticulosis 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. → Pres 2 No 3 Probably XXUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Thrombosus Vendus autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Meyelopuli, MD Res-000 JULY 16 2008 Amer Malhin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMAR MADHURZ Sinai Huspital of Baltimore MANGALAPUDI, MID 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JULY

1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7-15-2008 **Physician** 3:20AM /Medical Mildred L. White 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. Stella Maris Hospice Timonium
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5-22-1920 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2√□ F 233-26-8193 88 West Virginina Director Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other then "natural", or items 23e or 28a-f show injury or other traumatic event, the Modical Examinar must be notified at Funeral Director 1 ☐Yes 2 ☐No Md. Balto. Nottingham 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4221 Chapel Rd. #203 21236 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give \(\Lambda \) Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No Specify: White Completed by Specify: 3 ₩ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other then "n. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Lawrence Arbogast Mary N. Eary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Peges 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. Deborah Fiore 7 Millbridge Ct. Nottingham, Md. 21236 Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 7-19-2008 F1kridge Meadowridge 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) PANCREATIC CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burlal-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of deeth
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy The certificate I 1 □ Yes 2 **X** No of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation death. 1 ☐Yes 2 ☐ No 2 Accident hours after death 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 29a, Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 ☐ Medical E warminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16108 H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TARIQ MAHMOOD TIMONIUM, MD 21093 31. Date filed (Month 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2 Date of Death **Physician** 17, 200 8 2:00 AM /Medical Examiner oward Birthplace (State or Foreign Country) If Under **Funeral** 1 🗆 M Director 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 MNo injury or other traumatic event, the Medical Examiner must be notified Director umbia 10g, Citizen of What Country? 10f Zip Code 6 items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturai", or 1 ☐ Yes 2 No Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retire) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than College (1-4or 5+) al Route Number, ElKridge, MD 21075 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 6920 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ R 3 ☐Removal from State A proximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one oguse on each line. EREBROVASCULAR Immediate Cause (Final THEROSCHEROTIC BUSEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, g DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy perform 2 No funeral director, 25. Was case referred to medical examiner? 26. Plac - Death Check onl one Be Hospital: Other: ၉ 1 ☐ Yes 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending Natural 5 ☐ Pending investigation Injury 1 🗌 Yes 2 □ No 2 Accident completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier llram 1) 28575 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 203. Smith AVE AKHAN, MINEEM 2835 31. Date filed (Month, Day, Registrar's Signature Year) State 1 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** aura /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M Director 219-34-0648 Jan 7, 1933 Virginia Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD 1 □Yes 2√□No Harford Director Edgewood 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1614 Swallow Crest Drive 21040 USA Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 2 Specify: white 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) caregiver Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Houston Kitts Lettie Bell Repass 9006 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah A. Conklin/daughter 132 Philadelphia Road Joppa, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SUND 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Evneral Service Loadse Pleasant 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore, MD 21201 23a. Part1. Enter the disease, Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TIC /Medical Due to (or ask consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 105 and Due to (or as a consequence of) the attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow ģ conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à Records, law requires 1 Yes 2 No Probably 4 □Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performe The death? 1 ☐ Yes 2 ☐ No Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3□ DOA Medical Certification: To 1 Inpatient this Manner of eath Natural ACCident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Hospital or Attending Division (Month. Day Year) 5 Pending Injury s after dea... seral Director: Artifled in by the investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person Upper Chasapeake Prive, Bel InD 11/19/00 amo 59 31. Date filed (Month, Day, Year) 32. Restrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** JOM as 1 QV 11 00:05 M 07 2008 /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, **Funeral** Year) 213-78-652 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code "natural", or Items 23a or 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 2 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FINIShe Resto 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) h and Mental H Be should be 19a. Informant's Name/Relationship (Type. Print) ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health tem 27 l SISTER BALTU NYIA ALAMeDA 100 nise Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 07-16-0X MARGIANI Signature of Funeral Service Licensee 22. Name and Address of Facility 2126 4600 WBER 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a ridiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PHELIMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner RENAL END STAGE that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 2 No 3 Probably 4 √Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier Allghatol RES-DOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GODD SAMARITAN HOSPITAL ABHIJEET GHATOL, 5601 LOCH RAVEN BLYD. BALTIMORE 21239

DHMH 17 Rev 1/2001

State

Registrar

THOMA

Raistrar's Signature

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200 /Medical or Location of Death acility Name (If not institution. Examiner 8. Date of Birth (Month, Day, Age (In yrs. last birthday If Unde Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Days Hours bз 218-58-2976 MD 56 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 XYes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with U.S.A. 21213 1311 Kenhill Ave 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Mantal Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 Yes 2 1 If Yes, Give Year or Dates: Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Various Jobs <u>llth grade</u> Laborer na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alma Pinkston Stanely Sherwood Willis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar of Health a 1311 Kenhill Ave, Baltimore, Md 21213 Roslyn Jackson-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 7/21/08 Woodlawn, King e Licensee 21. Signature of Funeral 5 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death 23a. Part1. Enter the a sease, or complications that ca shock, or heart failure. List only one cause on ea ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 00 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has b autopsy certificate furieral director, 25. Was case referred to medical 26. Place of Death (Check only one Medical Certification: To Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Af er this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation (Month, Day Year) Injury death. 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician:

neral Director: A

within 24 hours a To the

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

8 2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JULY 2008 11:56 MM JOSEPH Ε. WRIGHT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Days Min. Months Hours 214-26-5201 Oct.16,1932 Maryland Director 75 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Model Examiner must be notified at Baltimore County 1 ☐ Yes 2XXNo Maryland Baltimore Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21236 USA 4519 Fullerton Avenue Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ... any lijury or other traumatic excess. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married White 1 ☐Yes 2 ☑ No Specify: If Yes, Give Year or Dates: 1955 •1959 Specify: ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Coast Guard 4 yrs Electrician 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Webster John G. Wright မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4519 Fullerton AVenue Baltimore, Md. 21236 Barbara M. Wright (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 7=18=08 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 4 Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses ^{22.} Name and Address of Facility al Home 6.7. Las 7401 Belair Rd. Baltimore, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) SEPSIS /Medical Due to (or as a consequence of): Examiner METASTATIC CANCER Sequentially list conditions, if any tention of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examine The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi <u>PNEUMANIA</u> Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ⋛ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No this certificate 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1€ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certi D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON. 21204 TABASSI x Year) 1 8 2008 MD 7601 OSLER DRIVE 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- StateAmend 26 perVerbal G881 7/18/08 TTificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 1^{Day} **Physician** 2008 9:45 a M Charles Ph.D. Weiss, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimore 7006 Rock Stream Ct. 8. Date of Birth (Month, Day, May 30, 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours 1937 Months Days Min. 11XM 2 1 F 062-30-2437 71 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director Erie East Amherst NY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14051 USA 70 Fennec Lane Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🛪 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Clinical Psychologist Psychology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernice Guggenheim Arthur Weiss, MD. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 70 Fennec Lane East Amherst, NY. 14051 Mrs. Catherine Weiss/ Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Co. :7**-**18**-**08 Towson, Md. 4 Donation 5 Dother (Specify) ^{22. N}สันให้ down son Towson, Md. 1050 York Rd. Towson, Md. 21. Signature of Funeral Service License nuch 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of peach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SNC Westic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No Physiclan: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 3 Residence 6 Other (Special) Aughters 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification; To this funeral 28b. Time of Injury To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

Medical

DIRECTOR,

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

MEDICAL ONCOLOGY

023675

2917 18' 500R

30. Name and address of person who completed cause of death (Item 23a) (Type, I Johns Hoplans Comer (

Bettruone, W

(Check only

29b. Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day 20 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner OWSON tos 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Sex **Funeral** Months Days Hours Country) 1 M 2 F Yrs. Director lar Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, I'm Medical Examinar must be notified at Director 1 res 2 No 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21206 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes, 2 Fil No
If Yes, Give
Year or Dates: by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be l 2 should be fi h and Mental H ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura Route Number, City of Town, State, Zip Code) If Item 27 Pages 1 and Lawrence UOUYR 20b. Place of Disposition (Name of cemetery, crematory or others 20a. Method of Disposition 20c. Location - City or Town, State Important: It any Injury o 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and physician a s the burial-Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for o 9 Unknown 9 🗀 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 X No 3 Probably 4 Unknown should 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 After this certificate 2 No 1 ☐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOSPICE 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury death. 1 Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON 6701 Chango SI AMEN

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

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32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 16 **Physician** July 8:39 PM 2008 Harold William Yates /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min Days 1 ☑ M 2 ☐ F 03 215-30-8173 76 1931 Director Nov. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Exproductions invest to profibe 1 at 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1221 Cathedral Drive 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Advertising Marketing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yates Wilhelmina Griffner Joseph မ Pages 1 and 2 should Saltimore, Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1221 Cathedral Drive, Glen Burnie, MD 21061 Annie M. Yates (spouse) July Date 21 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cem. 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Juneral Service Lice 23a. Frt1. Enter the 1 ease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only the cause on each line.

Immediate Cause (Final 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death **Physician** YVESE Cardiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Disease Examiner DYDNAYY Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Physician: The law requires that the death certificate be executed burial-transit signed by the attending physician and be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred or Attending 5 Pending investigation 1. Natural nours after death.

neral Director: Af

filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Hospital **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated 29b. Signature and title of certifier anite Chandelwa Sun D0052490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khandelwal MD 3001, S. Hanover Street Balkimore MD 21225 32 Registrar's Signature 31. Date filed (Month, Day, Year) JUL 1 8 2008 Registrar

/lark	c Edwin Zac		State of Maryland / Department of Health and Me 1-For State Certificate of Death	ental Hyg	iene Reg.	No. 20	n e	23	19
	Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death		3. T	ime of Death	
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			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 3011 Lost Creek Boulevard Laurel	ion of Death		4c. County of Dea			
			3011 E03t Oreck Bodiovard	Jnder 24Hrs. 8	B Date of Birth/	MM/DD/YYYY) 9. E		ce (State or	
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8	rs afte ural", miner	2	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No spec 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (G		k done 1	6b. Kind of Busines			
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			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery			20c. Location - City			
	Baltimore, permit. Pages I as Department of Her Important: If ite injury or other tr		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Denoting 5 Other Sympty: W. Arundel Crematory	v Jul	18,08	Odenton,	Ma	ryland	
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	760 cate b physic	§	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	ctopic pregnan	04	23d. Date of del	ivery Day	, Ye	ar
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7	Division ital or Attendius after death.	icat	2 X Accident Investigation PRI //14/06 PRI 1534 ITS	ing. etc.	28f. Location (S	treet and Number of	or Rura	Route Numb	er City
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3	Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date ar (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea	and place, and o ath occurred at	due to the cause the time, date a	e(s) and manner as and place, and due	stated to the	cause(s)	
	To With	Mec	29b. Signature and title of certifier 29c. License nur			29d. Date signed			
1	6		Talana 1177 O.C.M.E	Ξ.		July 15, 2008	š		
	6		30. Name and address of person who completed cause of death (Item 23a)	aro MD 240	201				
	U		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimo	VID 212		-			
	Regi:	state strai	31. Date filed (Month, Day Year) 2008 32) Registrar's Signature						
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State of Maryland / Department of Health and Mental Hygiene 1 - State amend #5 Per FH G883 9/17/08 dertificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Milton Samuel Zaslow July 15, 2008 3:18 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 5 Social Security Num 154–05–358 Birthplace (State or Foreign Country) 1 X M 2 □ F Days Yrs. Director 87 May 22, 1921 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Medical Examinat must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 XNo MD Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9039 Sligo Creek Parkway #308 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Ir Yes, Give Year or Dates: 1942–46 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 💢 No Specify: \$ 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Deputy Director National Security Agency 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Samuel Zaslow Lena Shenheit 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any Injury or other trau once. William Zaslow/son 8765 East State Hwy. AD Rogersville, MO 65742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 07/18/08 Beltsville, MD 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate shock, or heart failure. List only one cause on each line.

Immediate Cause (Final **Physician** ARDIO PULMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARDIAC TEMPONADE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit VALVULAR P.O. Box 68760, Due to (or as a consequence of): Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) ed by the signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? tX Yes 2 No 3 Probably 4 Unknown Completed peen VASCULAR DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed?
Yes 2X No certificate 1 □Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home To the Hospital or Attending Physiwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 ☐ Yes 2 🔀 No 2 ¶ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number aniedobetz FA037852 3041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edith Aniedobe, M.D. 1500 Forest Glen Rd. Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 12:15 A M **Physician** July 7, 2008 Η. Albert Eugene /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Temple Hills 3922 23rd Place If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Nov. 30, 1918 Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Months 89 1**XX**M 2□ F Pennsylvania 198-01-8495 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Prince George's Temple Hills Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20748 3922 23rd Place Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1936 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1936 within 72 hours after 1 □ Never Married 2 □ Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes, Give þ Year or Dates: 3 XWidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) U.S. Navv Chief Warrent Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Heilman Catherine Jones Roscoe Albert ൧ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 992 St. John Dr., Annapolis, MD 21409 Scott Hackard / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Arlington National Cemetery 10/03/2008 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home FA 21. Signatur of uneral Service Licenses 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending p IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9∏Unknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Unknown sate has been signated bade 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 2 No the Hospital or Attending Physician; director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral Manner of Death 28d. Describe how injury occurred 28a. Date of Injury 28h Time of 28c. Injury at Work? After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier

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and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the a this 4 hours after death.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 2, Benjamin Franklin Guy Andes , Jr. 2008 6:26 Рм 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y Feb. 15, 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 □ F 578-24-0755 83 Feb. 1925 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Washington, D.C. 1 Yes 2 No D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1328 T Street, S.E. 20020 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Government permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important; If item 27 is marked other tha any injury or other traumatic event, the I Supply Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin Franklin Guy Andes, Sr. Nellie G. Hulvley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Wyatt / Daughter 14104 Spring Branch Dr., Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Cedar Hill Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/8/2008 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Juneral Service Licensee 21. Signature George ad Padre Kaffasiy Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. ENCE PHACO PATHY Imme lat Cause (Final ANOXIC Physician resulting in death) /Medical Due to (or as a consequence of): Examiner MEMORRUAGIC Sequentially list conditions, Examiner It any, leading to immediate cause. Enter Underlying Cause (Disease or injury GASTRO INTESTINAZ that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ hknown Completed Were autopsy findings available prior to completion of cause of doath? 24a. Was an autops) perform death? 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3885 2008 0 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
VENKAT. S. Kamaman 7501 SURRATIS ROAD #1307 10H Curron 1501 JUL 08 Registrar

Charles Walter Bur		St For State	ate of N	Иarylar	nd / Depar <i>Certi</i>	tment of <i>ificate of</i>	Health Death	and	Menta	al Hyg		eg. No	20	0.8	2319
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213 buld b l Men mar ic eve	5	Joseph L. Bu 19a. Informant's Name/Relation				19b. Mailin	g Address	(Street	t and Num	ber or Ru	ral Route Nu	ımber,	City or Town, Sta , MD 206	e, Zip Code)	
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m galie	İ	MUMMA	(\mathcal{O}_L)	July	12/10		4001	Benn	ing	Road	, NE W	ash	ington,	DC 200) 19 mate Interval
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the bineral director.	٤	Part II. Other significant cond		Unkno	own o death but not re	eulting in the	underlying	cause	niven in P	art I.	23e. Dio	tobac	co use contribute	to the cause	of death?
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Division of Vital Records, tal or Attending Physician: The law require rs after death. all Director: After this certificate has been si led in by the funeral director, page 2 should be.	ᇹ	27. Manner of Death 1 Natural 5 Pe	ending	Jun 25,	Day Year) 2008	2335 hrs	,,	_	Yes 2 ✓	No I	Driver of 1	moto	rcycle that co	lidid with	a motor
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Division of Vital Records, P.O. E To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director.		4 Homicide 29a. Certifier 1 Certifying	Physicians	To the he	et of my knowled	ne death occ	urred at the	e time. c	late and p	lace, and	due to the c	ause(s	and manner as s	tated.	
the H nin 24 the F	g	(Check only one) 2 Medical E	xaminer:Or	n the basis	of examination a	nd/or investig	ation, in m	y opinio	n, death c	occurred a	t the time, da	ate and	d place, and due to	the cause(s	:)
To To com	Medical	29b. Signature and title of cert	an	nd manner s	stated.				se numbe				9d. Date signed (
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0		30. Name and address of pers	on who com	npleted cau	se of death (Iten	n 23a)		-							
W 15)	88		tant Med			Penn Str	eet, Balt	imore,	MD 21	201					
Sta	te	31. Date filed (Month, Day, Yea	ar)	32. R	egistrar's Signat	ure	,								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Phalena Month Year **Physician** prittingham 2008 29 17:32 Karen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl Examiner Baltimore City The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖰 F Days Hours **Director** 212-72-2155 48 June 24. 1960 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show 1 x Yes 2 □ No r 28a-f s notified Directo Maryland Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code must be n ö 9100 Reedy Cove Drive, # 304 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. traumatic event, the Medical Examiner 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🗓 No Specify à Specify: 3 Widowed 4 Divorced Black "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th laborer U. S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I Robinson Jeremiah Brittingham Annie Lois Farmer ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Natasha Brittingham/daughter Department of Heath a Important: If item 27 Is any Injury or other trainonce. 131 Flower Street - Berlin, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul UMC Ceme. July5, 2008 Berlin, Maryland 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD 21. Signature of Funeral Service License atricia JOLLEY MEMORIAL CHAPEL, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Due to (o as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or as a consequence of) Sclerodermo Exami that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death
9 Unknown Dav 5 Other (specify) page 2 should be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, ypertension end-stage 1 Tyes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tal or Attending. ...,
urs after death.

ral Director: After this certificate has be Stenosi autopsy 2 INO 1 Tyes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 - Homicide 24 hours Hospita 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

To the within 2

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 3 2008 Keller Sara

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Registrar's Signature

Vled, Ca

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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			T = For State Registrar		,	Cert	ificate of	Death		F	Reg. No.	2008	23201
Ė	Physici	an	1. Decedent's Name (First, Middle, L.	ast)						ate of Dea	ath Day	Year	3. Time of Death
,	/Medic			James Roy	Brown					June 2		2008	12:10 P M
Walter Co	Examin	er	4a. Facility Name (If not institution, gi				4b. City, Town, or				4c.	County of Deatl	
			3478 Constellat: 5. Social Security Number 6.		(In yrs. last birt	hoh (d)	Davids If Under 1 Year	sonvill		ate of Birtl	h	Anne A	
	Funeral Director	8		1 M 2 □ F		rs.	Months Days		Min.	Month, Day	, Year) 1943	Co	pplace (State or Foreign intry) nington, DC
	aryland show d at	_	10a. State 10b. County		10c. City, Town	or Loca	ation						10d. Inside City Limits 1 ☐ Yes 2 X No
	ne Ma 8a-f s	Directo	Maryland Anne A	rundel	Da	avio	lsonville	2					
	with the a or 2		10e. Street and Number 3478 Constellat:	ion Dr			10f. Zip Code 2103	25			10g. Citiz	zen of What Co USA	untry?
	hs 23 musi	Funeral	11. Marital Status	12. Was Decedent F	ver in U.S.	13. W	as Decedent of H Yes, specify Cuba		n? (Specify	Yes or No-	. 1	14. Race - Amei	ican Indian,
38	be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ∰ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ဤYes 2 ☐ N If Yes, Give Year or Dates: 1			Yes, specify Cuba □ Yes 2 X No	Specify:	Puèrto Ricai	n, etc.)		Specify: Wh:	
Š	72 hound	Completed	15. Decedent's E (Specify only highest g		16a.	Decede	ent's Usual Occup	ation	of working	Ţ	16b. Kir	nd of Business/I	
7	ithin 7 ne. nan "r	nple	Elementary/Secondary (0-12)	College (1-4or 5-	-) [ind of work done of NOT use retired	danny most o	ii workiiig				
2	led w lygier her th	Co	12th	41		Stea	mfitter	40 M-111-	None /Fi			Constr	uction
and	l be fi	Be	17. Father's Name (<i>First, Middle, Las</i> Charl	es Brown				18. Mother's	Lucill			Surname)	
Š	should I and Men s marke	오	19a. Informant's Name/Relationship		19b	Mailing	Address (Street					r Town State 7	in Code)
<u>8</u>	es 1 and 2 should be filed w of Health and Mental Hygier I Item 27 is marked other th r other traumatic event, th		Jeanne M. Brown				Constella				-		•
ē,	es 1 and 2 of Health a fitem 27 is r other tra	Y 19	20a. Method of Disposition		20b. Place of	Disposi	tion (Name of atory or other place	i	Date	avius	20c. Lo	cation - City or	Fown, State
Baltimore, Maryland 21215-0036	permit. Pages Department of I Important: If Its any Injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify)		s Cr	rematory	7	7/1/08			gewater	
Ra	permit. Departi Importi any Inj		YWAT THE				Name and Address						ral ноme MD 21037
			23a. Part1. Enter the disease, or cor shock, or heart failure. List onl	nplications that caused one cause on each lin-	the death. Do n	ot enter	r the mode of dyin	g, such as ca	ardiac or res	piratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Metast	atic ca	ncer							Onset and Death
	/Medical Examiner		resulting in death)	_	consequence o	f):							
		-	Sequentially list conditions, if any, leading to immediate	b. Lung c	consequence	f):						-	
	uted J ansit	min	Cause (Disease or injury		,								
<u>,</u>	execting and rial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence o	f):							
68/60	The law requires that the death certificate be executed te has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Medical		d									
Ų.	ertifica ling ph		IF FEMALE:	20- 15									
ô	eath ce attendir for use	sian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)	1			2	23d. Date of deli Month	very Day Year
o.	ires that the de signed by the a i be detached f	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	and or death		Outer (Specify)						
7	s that ned b e deta	by Pi	Part II. Other significant conditions	contributing to death bu	t not resulting in	the unc	derlying cause give	en in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
vital Records,	w require been sig should b	ed b							_	1 🔼 Y	es 2	□ No 3 □ Pro	obably 4 ☐Unknown
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<u> </u>		Som								perfor 1∐ Yes	rmed?	death? 1 ☐ Yes	2□No
<u>[</u>	siclan; Th certificate rector, pag	Be (25. Was case referred to medical examiner?	Harris II			1	26. Place of					
0	Physiclan; r this certific ral director,	P _C	1 Yes 2 No		t 2 ER/Out			4 LI Nursi				Other (Spec	sify)
	ing Afte une	Certification:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day		ime of ijury	28c. Injur Worl	yat k? Yes 2 ∐ No		Describe h	iow injury	y occurred	
UIVISION	Atter	ifica	3 Suicide 6 Could not l 4 Homicide determined			m, stree	et, factory, office		28f. L	ocation (S	Street and	d Number or Ru	ral Route Number,
5	pital or ours afte eral Dii filled in	Cert		Januari, oto	. (ороблу)					ony or row	ni, Giale)	,	
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Medical	29a. Certifier 1 \(\overline{\text{M}}\) Certifying P (Check only one) 2 \(\overline{\text{M}}\) Medical Example (hysician: To the best o miner: On the basis of and manner sta	examination and	death dor inve	occurred at the tirestigation, in my o	me, date and prinion, death	place, and o occurred a	due to the o	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	4.	11	1	29c. Licens			2		e signed (Month	,
1	10tha	7	30. Name and address of person who	completed cause of de	ath (Item 23a)	Type. P		3306			Ju1	y 1, 20	08
	Mass		Curtis Harris, N	I.D. 900 B	estgate	Rd.	. Ste 30	0, Ann	napoli	s, MI	214	101	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 2	2008 32. Pegistra	r's Signature	1	وكلين						
-		204				7							

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08-04985 Michael Lamont Beverly Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 23202

		1- For State Registrar	•	Certifi	icate of	Death		F	Reg. No.	200	0 2020
Physici		1. Decedent's Name (First, Middle,La		····				2. Date of Dea		Year	3. Time of Death
ledical Exam	iner							June 28,	2008		0438 hrs
		4a. Facility Name (if not institution, giver Prince George's Hospital			4t	Cheverly	Location of Dea	ath		County of Death rince George	
Funeral	¥	Social Security Number 6. S	ex 7. Age	(In yrs. last b	oirthday)	If Under 1 Yea	r If Under 24H	Irs. 8. Date of B	rth (MM/E	DD/YYYY) 9. Bir	thplace (State or Foreign
Director		220-86-4844	M 2 F	33	Yrs.	Months Day	s Hours M	FEBRUAR	Y 22,	1975 MA	RYLAND
any.		Usual Residence of Decedent 10a. State 10b. County		Oc City Toy	wn or Locatio	n					10d. Inside City Limits
		MARYLAND CHARLE		WALDO							1 Yes 2 No
daryland 28a-f show 1 at once.	ector	10e. Street and Number		WALLO	- T	10f. Zip Code			10a. Citiz	en of What Cou	A
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygique. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Dire	12204 WENDY LANE			l	2060	1	141		ED STAT	<i>'</i>
with ms 23;	eral	11. Marital Status	12. Was Decedent E	ver in U.S.		Decedent of His	panic Origin? (Specify Yes or N	0- 1		ican Indian, Black,
death or ite	Fun	1 X Never Married 2 Married	1 Yes 2 A	No		s, specify Cubar		rto Rican, etc.)		White, etc.	
s after ral",	by		If Yes, Give Year or Dates:			Yes 2 X No				<u> </u>	ACK
"natu Exan	ted	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	nly highest grade comp College (1-4 or 5+			s Usual Occupat st of working life.			16b. Ki	nd of Business/	Industry
36 thin 72 te. than edical	ompleted	Lionidinary/oddoridary (0-12)	3 YEARS	′	CERTI	FIED WE	LDER		I	RON WOR	ĸ
5-00 ed wit fygien other he M	Con	17. Father's Name (First, Middle, Last)				18.Mother's Na	me (First, Middle,			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	JOSEPH LOUIS BEVI					SHIRLE	Y ELOISE	SMO	THERS H	ART
b, MD 21215-0036 and 2 should be filed within 72 hours a teath and Mental Hygique. tem 27 is marked other than "natural traumatic event, the Medical Examin	To	19a. Informant's Name/Relationship (*SHIRLEY SMOTHERS						or Rural Route Nu			
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		20a. Method of Disposition	naki / MOI			on (Name of cer		Date Date		Ocation - City or	YLAND 20616
Baltimore, MI permit. Pages 1 and 2 s Department of Health at Important: If item 27 injury or other traum			Removal from State	crem	natory or othe	er place)					
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Physician		23a. Part I. Enter the disease, or comp	olications that caused th	e death. Do							Approximate Interval
/Medical xaminer		failure. List only one cause on el Immediate Cause (Final disease a	Gunshot Wounds	(2) to H	ead and A	Abdomen					Between Onset and Death
Adminici		or condition resulting in death)	Due to (or as a conseq	uence of):							
	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):				_	_		2
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execuian an	/Medical	UNPENDED	AMENDED	-							
760, ficate be ex g physician the burial	Mec	IF FEMALE:	23c. If yes, outcome	of pregnance	су				23d.	Date of deliver	у
687 ertific	jan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at tir	no of dooth	=		Ectopic preg	gnancy	1 1	Month	Day Year
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 Unknow		ne or death	5 Othe	er (Specify)			7.0		
O. Hat the ed by the etached		Part II. Other significant conditions	contributing to death t	out not result	ting in the un	derlying cause g	iven in Part I.	23e. Did	lobacco u	se contribute to	the cause of death?
ires that the signed by	d by							1Ye	s 2 🗸	No 3 Pro	bably 4 Unknown
Records, The law requir ficate has been si	Completed							24a. Was			utopsy findings available completion of cause of
ecol he law ate has	E C							perf	ormed?	death?	
tal Recian: The	BeC	25. Was case referred to medical				26.Place	of Death (Che				
of Vital ng Physician: Ufter this certi meral director	ToB	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 🗸 ER/	/Outpatient	3 DOA	Other Nur	sing Home 5	Residen	nce 6 Othe	r:
Ing Pl		27. Manner of Death 1 Natural 5 Page Natural	28a. Date of Injury (Month, Day,Yea FOUND:	28t	b. Time of Inj DUND:		ry at Work?	28d. Describe Subject she		ry occurred	
Sior Attence death death sctor:	catic	2 Accident Pending Investigation	on Jun 28, 2008	01	45 hrs		res 2 ✔ No	. =;=			
Division tal or Attendi rs after death. al Director: A	Certification:	3 Suicide 6 Could not determine				factory, office b	uilding, etc.	or Town.	State)	nd Number of Ru Newburg, Mi	ural Route Number, City
F. E. S. F.		29a. Certifier	(Specify) Othe			d at the time de	ate and place a				
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 ✓ Medical Examine	On the basis of exami	_							
F 8 6	Me	29b. Signature and title of certifier	and manner stated.			29c. Licens	e number		29d. D	ate signed (Mo	nth, Day, Year)
		Carol &	talla	w		0.C.I	M.E.		June	28, 2008	
001	1	30. Name and address of person who		,	'				1		
006			nt Medical Exami		1 Penn St	reet, Baltimo	ore, MD 212	201 			
St Regist		31. Date filed (Month, Day, Year)	32. Régistrar's	Signature.	dos	de					
	_										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 23203

			1 - State Registrar	,	Ce	ertificate of	Death		Reg. No.	, , ,	
	7		1. Decedent's Name (First, Middle,	Last)			-	Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medic		James	Ва	les			June	30.	2008	10:00P M
	Examin		4a. Facility Name (If not institution,			4b. City, Town, c	r Location of Dea	ith	4c. Coun	ity of Death	
		e.	7720 Ann Harbo				Tobacco			Char1	
	Funeral			6. Sex 7. Age (In yrs	s. <i>last birthd</i> ay Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, Da	ay, Year)	Coun	**
h	Director		Usual Residence of Decedent	82				July 9	, 1925	⊥ New	York
	land ow at		10a. State 10b. County	10c. C	ity, Town or L	ocation				1	0d. Inside City Limits
	Mary -fsh fied	ţō	MD Ch	arles	Port	Tobacco					1 ☐ Yes 2 No
	r 28a	irec	10e. Street and Number	11100	1016	10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	h with	a D	7720 Ann Harbo	r Drive			20677		US	SA	
	deat	Funeral Director	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13	. Was Decedent of H	lispanic Origin? (Specify Yes or No		ace - Americ lack, White,	
2	after or it	J.	1 ☐ Never Married 2 ☐ Marrie			1 ☐ Yes 27 No	Specify:	,	Spec		hite
3	ural",	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:			. ,				
5	"nat	Completed	15. Decedent' (Specify only highes	s Education t grade completed)	i (Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of we	orking	16b. Kind of	Business/Inc	Justry
7	withir ene. than he M	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5+)		ld Represe	,		Donald	Cam	_
7	filed Hygi ther int, tl		17. Father's Name (First, Middle, L	.ast)	TIE.	id Kepres		ame (First, Middle		x Corpanne)	P •
o	ld be ental ked c	To Be	Constantino Ba	ales			Irene	Gaguras			
<u></u>	shou nd M mar	F	19a. Informant's Name/Relationsh	ip (Type. Print)	19b. Mai	ling Address (Street			oer, City or Tow	n, State, Zip	Code)
Ž	nd 2 alth a 27 is		John Bales/Son	ı	P.O.	Box 276	6, La P1	ata,MD	20646		
ָט ב	item		20a. Method of Disposition	20b.	Place of Disp	oosition (Name of ematory or other pla	ce)	Date	20c. Location	1 - City or To	own, State
Dalimio	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	i	1 XBurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 Linemoval from State		l Veterans		/9/2008	Che1te	nham,	Maryland
<u> </u>	permit. Departr Importa any inju		21. Signature of Funeral Service L	icensee M0094	45	22. Name and Addre AREHART—I	ess of Facility	IINEDAT H	OME D V		
۵	8 8 8 8		23a. Part1. Enter the disease, or	(chola)		211_St_N	fary's A	ve. Ia P	lata.MD	206	46
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused the dea only one cause on each line.	ath. Do not e	nter the mode of dyi	ng, such as cardi	ac or respiratory a	irrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	B-Cell	L Lymph	noma					Onset and Death
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dus to (or as a consa		diac Dise	2000				
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00	icate phys s the	Medical		d							
3	certifica nding ph use as ti		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregi		_			23d. [Date of delive	ery
á	death atter	hysician	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		☐Ectopic pregnanc	:У			Month	Day Year
)	t the	hys	9 □ Unknown	9□Unknown							
Ų,	s tha jned l e det	by P	Part II. Other significant condition	ns contributing to death but not re	sulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco use co	ntribute to the	he cause of death?
5	equire en sig ould b							. 1 🗆	Yes 2 No	3 ☐ Prob	oably 4 □Unknown
))	law re	plet						24a. Was	an 24	o. Were auto	opsy findings available impletion of cause of
	The ate ha	Completed						perf	ormed? 2 X No	death? 1 ☐ Yes	
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_	ing P		27. Manner of Death 1 ANatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo		28d. Describe	how injury occ	urred	
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>	or Al	Certification:	4 ☐ Homicide determi		cify)	street, ractory, office			(Street and Nur wn, State)	nper or Hura	al Route Number,
	pital ours a leral filled		29a, Certifier 1 [™] Certifying	Physician: To the best of my kr	nowledge, de	ath occurred at the t	ime, date and pla	ce, and due to the	e cause(s) and	manner as s	stated.
	24 h	Medical		Examiner: On the basis of examination and manner stated.							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	29b. Signature and title of certifier	1/1		29c. Licen			29d. Date sign		
}				ALLE		D2	3021		Jul ₂	y 3, 2	:008
(30. Name and address of person								
/	DABI		S.K. Mishra,M.	D. 7-C Post Off	ice Rd	. Waldorf	,MD 206	502			
	Sta Registi		31. Date filed (Month, Day, Year)	3 2008 Superior Sign	nature	Soule					
	negisti	ell.	10F A	O LOUD	/						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death ^Дау, JüÏy Melvin R. Bearman 2008 4c. County of Death 4b. City. Town, or Location of Death Baltimore 7. Age (In vrs. last birthday)

1. Decedent's Name (First, Middle, Last) **Physician** 2:29 ам /Medical 4a. Facility Name (If not institution, give street and number) Examiner 5200 Talbot Place Halethorpe nder 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days **№** M 2□ F Director 213-07**-**7315 90 2/26/1918 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 □Yes 2 □No Md. Baltimore Director Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5200 Talbot Place Completed by Funeral 21227 12. Was Decedent Ever in U.S. Armed Forces? 1943- Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 If Yes, Give 1945 Year or Dates: 1 ☐ Yes 2 XNo Specify 3€ Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other transmitted. 7yrs Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Bearman 2 Louisa Koester 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie B. Ripke/daughter 5200 Talbot Place Halethorpe, Md. 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory Inc. 7/5/2008 Hanover, Md. 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. Signature of Funeral Service Ocense MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (unas a consequence of): Examiner lany, Learn to minedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Honknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1∐ Yes Division or Vital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Certification: To 1 TYes 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I t 🗲 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

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State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** July 2 2008 Helen M. Beigel 11:30 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Brighton Gardens Columbia If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 M 2 XF 85 8-8-1922 MD Director 217 18 8092 Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or Items 23a or 28a-f show r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo Director MD Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or 21045 7100 Minstrel Way United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Healthcare Financing Analyst Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental h should be Joseph Carroll Carrie Shuppel 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 Is 2733 Woodridge Court West Friendship, MD 21794 Doug Beigel/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Crematory 7-3-2008 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Ulus 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dementia Immediate Cause (Final 5 years **Physician** Alzheimer 15 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): physician a Box 68760, Physician/Medical the as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🖾 No Ö the 9□Unknown 9 Unknown signed by t م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division or Attending 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: , 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. July 3, 2008 586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li 8600 Snowden River PK #301, Columbia, MD21045 PKWY 31. Date filed (Month, Day, Year, gistrar's Signature State JUL 0 2008 Registrar

			For State Registrar	State of	Marylan		artment of I rtificate of		and Mental	Hygier Reg. I	0000	23206
	Physici /Medic		1. Decedent's Name (First, Middle, La Gary Howard Baese	st)					2. Date of Month	1	2008 ^{Year}	3. Time of Death 12:25 A M
)	Examin		4a. Facility Name (If not institution, giv			(4b. City, Town, of Hagersto	wn	24 Hrs 9 Date	of Division	4c. County of Death	
	Funeral Director		5. Social Security Number 6. S 270–26–9239 Usual Residence of Decedent	sex 12M 2□F	7. Age (In yrs. 67	Yrs.	Months Days	Hours	Min. Apri	h, Day, Ye. L 16,	1941 _{Ohio}	lace (State or Foreign htry)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilh and Mertal Hylgiene. In Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. County Maryland Washingto 10e. Street and Number 14014 Marsh Pike 11. Marital Status 1 \(\text{Never Married} \) 2 \(\text{Married} \) Married	12. Was Dece Armed For 1 X Yes	y Hage		10f. Zip Code 21742 Was Decedent of If Yes, specify Cut		igin? (Specify Yes n, Puerto Rican, etc	U.:	Citizen of What County S • A • 14. Race - Americ Black, White,	an Indian, etc.
0000-01717	led within 72 hours af lyglene. her than "natural", or nt, the Medical Exam	Completed by	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	If Yes, Give Year or Da ducation ade completed) College (1-2	e ites:	16a. Deced (Give life. I	1□Yes 2ÅNo dent's Usual Occu kind of work done DO NOT use retire SSIONAL F	hotog	st of working	Se	Kind of Business/Inc	dustry
ıı yıaıı	should be fi nd Mental F marked ott matic ever	To Be	17. Father's Name (First, Middle, Last Howard William Bac 19a. Informant's Name/Relationship (ese		19b. Mailir	ng Address (Street	Edna	Marie He	enric		Code)
nore, wa	ages 1 and 2 sent of Health art: If item 27 is y or other trau		Shirley Hoecker-s: 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	ister Removal from S	state	610 S Place of Dispo	-	Dr.	Springfie 7-8-2008	eld, (own, State
Dallillio	permit. P Departme Importan any injur		21. Signature of Funeral Service Lice	·	5111.	22	2. Name and Addre	ess of Facili	ty Douglas	s A	Fiery Fune erstown, M	eral Home
,0070	icate be executed Medical Examiner sthe burial-transit	dical Examiner	23a. Part1. Enter the diseas of on shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any reading to minimodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c	aused the death ach line. The state of the death ach line. The state of the state	uence of):	er the mode of dy		cardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death
O. DOX O	the death certific the attending pi ched for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outo 1 □ Live bi 4 □ Pregna 9 □ Unkno	inth 2 ☐ Feta antattime of d	l death 3 □	⊒Ectopic pregnanc ⊒ Other <i>(</i> s <i>pecify)</i> _	су		_	23d. Date of delive Month	ery Day Year
II necolus, r.	To the Hospital or Attending Physician: The law requires that the death certific Within 24 hours after death. Within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Completed by Ph	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying cause gi	ven in Part		1 ☐ Yes Was an autopsy performed	24b. Were auto prior to co death?	pably 4 Ninknown opsy findings available impletion of cause of
ISION OF VITAL	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 27 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined	28a. Date of (Montiling) 28e. Place	of Injury h, Day Year) of Injury - At he	ER/Outpatier 28b. Time o Injury ome, farm, str	f 28c. Inju	her: 4 AN iry at ork? Yes 2	28d. Desc No 28f. Local	Residence	e 6 Other (Specifinjury occurred	
Ś	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Scertifying Pl	buildir hysician: To the	ng, etc. (Specif	y) wledge, deat	h occurred at the t	ime, date a	City of	or Town, S	tate) e(s) and manner as s and place, and due to	stated.
	To the H. within 24 To the Fi	Medical	29b. Signature and title of certifier	and mann	er stated.	and and or in	29c. Licen	se number			Date signed (Month,	Day, Year)
Y	H-0		30. Name and address of person who Khalid Waseem, M							2174		<i>J J</i>
į	Sta Registr	_	31. Date filed (Month, Day, Year)		gistrar's Signa	ature	house					

			For State Registrar	State of Mar	yland / [rtment of H		and M	lental Hy	giene Bea. No.		
3	Physici	_	Decedent's Name (First, Middle, La Phyllis	st) Wollins	В	Burr				2. Date of De June 3	ath Day	2008 008 Year	32im3of2edt 7 8:00 A M
	/Medio Examin		4a. Facility Name (If not institution, given Hebrew Home of S. Social Security Number 6.5	re street and number) Greater Was	hingto		4b. City, Town, or Rockvi	lle		8 Date of Bir		County of Death	
in the	Funeral Director		295-18-8204 Usual Residence of Decedent	1□M 2□F	83	Yrs.	Months Days	Hours	Min.	8. Date of Birl (Month, Da May 15	y, Year) , 19:	25 Oĥi	O
	he Marylan 28a-f show otified at	Director	10a. State 10b. County Maryland Montgo 10e. Street and Number		0c. City, Tow Ch		Chase				10g Citi	izen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fiutry or other traumatic event, the Medical Examiner must be notified at ance.	Funeral Dir	4932 Bradley Bou	12. Was Decedent Eve Armed Forces?	er in U.S.	13. W	10f. Zip Code 2 /as Decedent of H Yes, specify Cuba	0815 ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	Uni	ted Stat 14. Race - Amer Black, White	ces ican Indian, , etc.
15-0036	72 hours aftu "natural", or i edical Examir	ठ्व	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 [2] Divorced 15. Decedent's E (Specify only highest gr	1 ☐ Yes 2 No If Yes, Give Year or Dates: ducation ade completed)	16a	. Decede	☐ Yes 2☐XNo ent's Usual Occup ind of work done of O NOT use retired	Specify: ation during mos		ing	16b. Ki	Specify: Wh	nite
Baltimore, Maryland 21215-0036	be filed withir tal Hygiene. d other than event, the Me	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Las	College (1-4or 5+) 4 Nathan W		omen	aker			e (First Middle, er Curt		wn Home Surname)	
Maryla	ind 2 should alth and Men 27 is marke er traumatic	은	19a. Informant's Name/Relationship Patricia Pancoe/	(Type. Print)	191	o. Mailing	Address (Street a Bradley						
timore,	t. Pages 1 a tment of He tant: If item ijury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Speci	fy)	cemete	ry, crem	ition (Name of atory or other place Cemetery	(07/0		Akr	on, OH	Fown, State
Ba	permi Depar Impor any Ir		Signature of Flueral Service Lice Service Lice		ne death. Do	25	Name and Addre DrChinsky 54 Carrol r the mode of dyin	1 St.	. NI	W. Wash	inat		20012 Approximate
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a	AKK	IN	SONISA	n -]	EI	NENT	TA C	OM PLS	Interval Between Onset and Death
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O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	☐ Fetal death		Ectopic pregnancy Other (specify)	'				23d. Date of deli Month	very Day Year
Records, P.O	w requires that i been signed by should be detai	by	Part II. Other significant conditions	contributing to death but	not resulting i	in the un	derlying cause giv	en in Part I	l.	23e. Did 1		use contribute to No 3□ Pro	the cause of death?
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Vita	siciar s certif irecto	Be C	25. Was case referred to medical examiner? 1 ☐ Yes No	Hospital: 1 ☐ Inpatient	2 🗆 ER/O	utnation	3□ DOA Oth	er:	e of Deat ursing Ho	h (Check only		6 □Other (Spec	nife()
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Division or	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigatic 3 Suicide 6 Could not t 4 Homicide determined	De 28e Place of injun		arm, stre		Yes 2□		28f. Location (City or To			ral Route Number,
	To the Hospital or A Within 24 hours after To the Funeral Dire completely filled in by	Medical C		hysician: To the best of miner: On the basis of e and manner state	xamination a								
) (To # To # comp	M	29b. Signature and title of certifies	Maio.			29c. Licens	C- F	74			ite signed (Monti	
	Sta	ato.	30. Name and address of person who	PATEL M	061	(Type, F	DO Print) MONTE	2058	- R	o, Rei	CKV	ILLEN	1008

State Registrar

JUL 0 3 2008

BURROWS PHYLLIS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day CHARLENE BIBBS Η. /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CLINTON REHAB & NURSING HOME ${\tt CLINTON}$ PRINCE GEORGE'S 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11/07/1912 9. Birthplace (State or Foreign LOUTSTANA 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min. Director 578-28-5559 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exenting must be notified at Director 1√2 Yes 2 □ No MD PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9211 STUART LANE 20735 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 \$ 1 □Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) HOUSEWIFE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE HILL NELLIE MAE HILL ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11011 SPYGLASS HILL MITCHELLVILLE, MD 20721 BARBARA STEWART/GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 07/03/2008 RIVERDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or Itijury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ils certificate has been signed by the director, page 2 should be detached 9 🗆 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 2**X** No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 4 A Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending hours after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ! Cenery D35206 07/03/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM T. MD 11701 LIVINGSTON ROAD FT. WASHINGTON, MD 20744 TANNER. 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JUL 0 7 2008 Registrar

Baltimore, Maryland 21215-0036

Examiner Attending Physician: The law requires that the death certificate be execute attending physician signed by the After death. rector: by the

Registrar

To the P within 24 To the R complete	To the Parkin 2. To the Complete Comple		To the Hospital or within 24 hours aft To the Funeral Di completely filled in	Medical Cer
	28	_	To the Vithin 24	Med

Certification: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P detest 22 5

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31. Date filed (Month, Day, Year)

JUL 0 7 2008

32. Registrar's Sigr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 9 30 P_M 2. Date of Death BUNN ON 200 SULY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CY TOSPITAL ALTLINDAE Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours 237-90-4535 2/7/1955 Nash Co. N.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1√TYes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Charles Plaza 604 21201 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ₩ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Librarian <u>City Library</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Bunn Sr. Oneta Ricks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5852 NC 48 Battleboro, N.C. 27809 <u>Oneta Bunn / Mother</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 K Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Hope Church Cem. 7/12/2008 Battleboro, N.C. 21. Signature of Fune I Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 64TIVE disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to complet death? 1 □ Yes performed? autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 | Yes 2 | No

Physician /Medical Examiner

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After this funeral

filled in by

ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director; After ti

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death certificate be executed

Box 68760

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Division or Vital Records,

Physician

/Medical

Examiner

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Director

28a-f show notified

d 2 should be filed within 72 hours after death with it and Mental Hyglene. 7 is marked other than "natural", or items 23a or 77 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a

Pages 1 and 2 s thrent of Health an tant; If Item 27 is i jury or other trau

permit. Page Department of Important; if any injury or

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Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant

27. Manner of Death

5 Pending investigation

28a. Date of Injury (Month, Day Year) 6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COSTA

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Natural

2 Accident

4 Homicide

3 ☐ Suicide

**Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

JUL 0 8 2008

29c. License number

PAUL PLACE

29d. Date signed (Month. Dav. Year)

NORE NO ZIZOZ

31. Date filed (Month, Day, Year)

22. Registrar's Signature

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28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 51

		ľ	For 1 - State Registrar	State of M	larylan		artmen rtificat			ind M		giene Reg. No	7 11 11	8	232	211
	Physici		1. Decedent's Name (First, Middle, I	.ast)							2. Date of De Month June 28	Day	, 008 ^Y	ear	3. Time o	f Death
	/Medio Examir		Kristi L. Brown 4a. Facility Name (If not institution, g	give street and number	·)		4b. City,	Town, or	Location o				County of	Death		_
	LAMIIII	101	Genesis LaPlata	Center			LaP1	ata				C	harle	S		
	Funeral Director		5. Social Security Number 229-29-1295	. Sex 7. A 1 ☐ M 2 ☐ F	ge (In yrs. 40	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min,	8. Date of Bir Month Da March	th Year)	968 v	Birthp Coun irg	lace (State fry) Lnia	or Foreign
	pu ,		Usual Residence of Decedent		10c Cit	y, Town or Lo	nation							1	Od. Inside C	City Limits
	Maryla I-f ehov	tor	MD 10a. State 10b. County Prince	George's		xon Hi										2 X No
	or 28	je j	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of Wh	at Coun	try?	
	th will	a C	712 Maury Avenu	e			2 07	45				US.				
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f ehow important: If item 27 is marked other then "naturel", or Items 23a or 28a-f ehow appring injury or other traumatic event, it is Medical Example must be multiled at once.	Completed by Funeral Director	11. Marital Status **Theorem Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 27 If Yes, Give Year or Dates:	? KNo		Was Dece If Yes, spe 1 Yes		ispanic Orion, Mexican Specify:	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.))-	14. Race - Black, Specify:	White,	etc.	
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Maryland	uld be file fental Hy rked oth	To Be (17. Father's Name (First, Middle, La Leroy Brown	st)							(First, Middle n Will:		Sumame)			
ary	should have	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street	and Numbe	er or Rura	l Route Numb	er, City	or Town, St	ate, Zip	Code)	
Σ	and 2 saith n 27 i		Joycelyn Bogans	- mother		_			Ct.,		tenham					
Baltimore,	Pages 1 ent of He nt: If Iten ry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		. .	Place of Dispo cemetery, crei thel C	matory`or (other plac	^(e) 7	/5/2	008		ocation - Ci xand r			
Balti	Departmit. Departmit. Importate ony inju		21. Signature of Funeral Service Lix		m	3,					1 and .					
	Physician /Medical Examiner		23a. Pan Enter the disease, or or control to the cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	aDue to (or a	us a consec	alic quence of):	Bel	est dyin	g, such as	eardiac o	r respiratory a	arrest,	-		Approxima Interval Be Onset and	etween
68760,	icete be executed physicien end s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c												
P.O. Box (the death certific y the attending pl iched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1	2 Feta at time of c	al death 3	⊒Ectopic p ⊒ Other (s						23d. Date Monti		ery Day	Year
	law requires that the deas been signed by the a	þ	Part II. Other significant condition	s contributing to death	but not res	sulting in the u	ındertying	cause giv	en in Part I			tobacco Yes 2	_	oute to the	he cause of pably 4	death? Unknown
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Σ.	ician: Th certificete rector, pag	å	25. Was case referred to medical examiner?	Hospital:				Oth	05 \/		(Check only					
Jou	ig Physician: ter this certific neral director,	on: To	1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pending	1 ☐ Inpa 28a. Date of In (Month, D	ijury	28b. Time of Injury		28c. Injur Wor	4 NI	ursing Ho	me 5 ☐ Res 28d. Describe		6 Other	· · · · ·	у)	
Division of Vital	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director,	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion 28e. Place of I		iome, farm, st	М	1 🗆	Yes 2 🗆		28f. Location City or To			r or Rur	al Route Nu	mber,
	the Hospital thin 24 hours e the Funeral I	edical C	29a. Certifier 1 Certifying (Check only one) Medical Ex	Physician: To the bes xaminer: On the basis and manner	of examina	owledge, dear ation and/or in	th occurred nvestigatio	d at the tir	me, date ar ppinion, dea	nd place, ath occurr	and due to the red at the time	cause(s	s) and man ad place, ar	ner as s	tated. o the cause	(s)
	To the within To the comple	₩e	29b. Signature and title of certified	1.0	1		29	c. Licens	e number			29d. D	ate signed	(Month,	Day, Year)	
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2	3		30. Name and address of person w	ho completed cluse of	death (Ite	m 23a) (Type					2n, w	FLO	off,	MO	, 201	502
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Physici	an	TARREST CONTRACTOR
/Medi		JAMES DUI
Examir	ner	4a. Facility Name (If not institution, give street a
		NATIONAL NAVAL MET 5. Social Security Number 6. Sex
Funeral Director		245-22-5851 Sex 1
Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	al Director	District of Columb 10e. Street and Number 3435 Holmead Place, N
-0036 hours after dea tural", or items al Examiner m	ed by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married
21215- 1 within 72 jiene. r than "nat the Medica	omplete	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Col 9 years
/land /	To Be Completed	17. Father's Name (First, Middle, Last) Alfred Brown
and 2 sho and 2 sho m 27 is m		19a. Informant's Name/Relationship (Type. Pri. Pamela Brown Smith —
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f st any Injury or other traumatic event, the Medical Examiner must be notified once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ☐ Censee
Physician /Medical Examiner	xaminer	23a. Part I. Eyer the disease, or complications shock, if heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
O. Box 68760, he death certificate be executed the attending physician and ched for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown
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To the within To the Communication of the Communica	Ž	29b. Signature and title of cartifier
		30. Name and address of person who complete
1		GERALD D. DENTON CD

2. Date of Death Day Month DLEY BROWN 2008 JUN 30 and number) 4b. City, Town, or Location of Death 4c. County of Death DICAL CENTER BETHESDA MONTGOMERY 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours April 15, 1926 North Carolina 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No ia Washington 10f. Zip Code 10g. Citizen of What Country? W #618 20010 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, as Decedent Ever in U.S. med Forces? Black, White, etc. Yes 2 □ No res, Give ar or Dates: African 1 ☐ Yes 2 1 No Specify: American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry leted) (Give kind of work done during most of working life. DO NOT use retired) llege (1-4or 5+) <u>Military Laborer</u> Government 18. Mother's Name (First, Middle, Maiden Surname) May Bell nt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 1516 Fort Davis Street, SE Washington, DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State al from State incoln Mem. Cemetery July 5, 2008 Suitland, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 Approximate Interval Between Onset and Death s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. METASTATIC LUNG CANCER Due to (or as a consequence of): due to (or as a consequence of): Due to (or as a consequence of): res, outcome pf pregnancy Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death 5 ☐ Other (specify) Unknown ng to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 1 Yes 2 🕅 No 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) d manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 12832 (MS) JUL Za d cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL MC USN BETHESDA MD 20889-5600 R 31. Date filed (Month, Day, Year) 32. Registrar's Signat

State

Registrar

JUL 0 3 2008

			1 - For State Registrar	State of Maryla			of Health and of Death		jiene eg. No.2 () () ()	23213
i di	Physici /Medi		1. Decedent's Name (First, Middle, Last) Darry1 Dwaune	Bing				2. Date of Dea		3. Time of Death 12: 20P M
	Examir		4a. Facility Name (If not institution, give str Prince George's Ho	eet and number) spital		-	wn, or Location of Decrey	ath	4c. County of Death Prince Ge	orge's
	Funeral Director			7. Age (In yrs	. last birthday) Yrs.	If Under 1 \ Months D	Year If Under 24 Hi lays Hours Mil	n. (Month, Day	Year) 9. Birthpl Count 1959 Washi	
	e Maryland 3a-f show tiffed at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		ity, Town or Lo					0d. Inside City Limits 17 Yes 2 □ No
	n with th	al Director	10e. Street and Number 1711 - 61st Avenue			10f. Zip Co	ode .0785	1	Og. Citizen of What Count United St	-
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any Inlury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral		Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Deceden f Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pue No Specify:	Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, 6	an Indian,
altimore, Maryland 21215-0036	within 72 h iene. than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) 12 years	ion ompleted) College (1-4or 5+)	(Give life. E		ccupation lone during most of w etired) gineer	orking	16b. Kind of Business/Ind	lustry
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8760,	executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if an cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a))).	of the	Liver				
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(3		30. Name and address of person who comp			rint)			July 1, 200	O
	Stat	e	Villamor S. Reyes, 31. Date filed (Month, Day, Year)	M.D. 6501 L 32. Registrar's Signa	andover	Road	Cheverly,	MD 20785		
	Registra	~	JUL 0 3 2008 Ke	1 A	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 0530 A M Ju1y 2008 11 Warren Walter Boulden, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Ceci1 Elkton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Yrs. Maryland MAR 20, 1923 Director 212-18-0095 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sh Important: If item 27 is marked other than "natural", or other must be notified any injury or other traumatic event, the Medical Examiner must be notified. Director E1kton Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21921 1240 Leeds Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 1 MYes 2□No If Yes, Give Year or Dates: War II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automobile Dealership Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Mazie Borland Warren W. Boulden, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1240 Leeds Road, Elkton, MD Kevin A. Boulden/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
North East
Methodist Cemetery Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition July 15, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2008 North East, MD 22. Name and Address of Facility Hicks Home for Funerals, 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequen Jof): Examine physician and s the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes No 24a. Was an autopsy performed? res 2 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Inpatient Certification: To 27. Magner of Death 1 Natural 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide Hospital Deptifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatui and title of certifier

State Registrar

DIL

31. Date filed (Month, Day, Year)

8

ORIGINAL

20. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sonmi

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours attendeath.

To the 24 hours attendeath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

21. Signature un Funiçai state de la la	DNLLS	Aberdee		rring-Carg	o Funeral	Home, P.A.
23a. Fart 1. Enter the dise e, or complications, or heart failure. List only on	cations that caused the death. Do no e cause on each line.	t enter the mode o	of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	END STAGE (E		FASE			Un Known
Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)	LITUS .	TYPE 2			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic preg 5 ☐ Other (spec			23d. Date of deli Month	very Day Year
Part II. Other significant conditions con	tributing to death but not resulting in t	ne underlying caus	se given in Part I.		o use contribute to 2 □ No 3 □ Pro	the cause of death?
				24a. Was an autopsy performed 1 □ Yes 2 🔀	prior to c death?	topsy findings available completion of cause of 2 □ No
25. Was case referred to medical			26. Place of De	ath (Check only one)		
examiner? 1 ☐ Yes 2 ② No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA	Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Spec	cify)
27. Manner of Death 1 234 Natural 2 □ Accident 5 □ Pending investigation	28a. Date of Injury (Month, Day, Year) 28b. Tir Inju		. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	ı, street, factory, o	ffice	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge, ner: On the basis of examination and/ and manner stated	death occurred at or investigation, ir	the time, date and place on my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)

Reg. No 2008

8. Date of Birth (Month, Day, Year)

June 20, 1930 Maryland

Year

2008

4c. County of Death

CECIL

10g. Citizen of What Country?

14. Race - American Indian,

Black White, etc.

Specify: white

16b. Kind of Business/Industry

Transportation

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

13,2008

Whitehall, Maryland

USA

3. Time of Death

11:00

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 XYes 2 No

2. Date of Death

Month

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JUL 1 8 2008

A. HAShmi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

AL

MO, VA Maryland Health Care System, Penay Point, MO 21902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 07, 2008 Year **Physician** 7:45 AM William Paul Chambers /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany The Kensington Cumberland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 □ F January 21, 1925 218-16-2751 83 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location r 28a-f show notified at 1 Yes 2 No Director Cumberland Allegany Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number "natural", or Items 23a or dical Examiner must be 21502 USA 1 Baltimore Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📈 No Specify: Completed by White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Ballistics** Mechanical Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental F Be Anne Chabot Francis Chambers ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5450 Oxford Way, Huntingtown, Maryland 20639 item 27 is other tra Teresa Chambers-Riskin- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: if it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Flintstone, Maryland Rocky Gap Veterans Cemetery July 11, 2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22, Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD 21539 8 East Main Street helm 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) disease Oronar **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): Physician/Medical the' as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Derlipidemia 2 No 3 Probably 4 Unknown 1 TYes icate has been significate has page 2 should b Completed hydrocephalous 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy nerforme 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 **N**O 2 ER/Outpatient 3 DOA ို 1 ☐ Yes 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Registrar

SVA

29b. Signature and title of certifier

31. Date filed (Month, Day,

32. Registrar's Signature

and manner stated.

N. Clais value

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3altimore,

Records,

Vital

29c. License number

Son Memorial Ave. Cumber land

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 5 per FH 881 //31/08 difficate of Death

State of Maryland / Department of Health and Mental Hygiene
Registrar

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1737 Karson Ryan Crawford Julv2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery County Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 23,2008 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 6. Sex 1 XM 2 ☐ F **Funeral** Days Maryland 9 None Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐Yes 🔏 No Director Washington County Hagerstown Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21742 13163 Clopper Rd by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Megan Bowman Crawford Deron Crawford ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13163 Clopper Rd. Hagerstown, MD 21742 Deron Crawford-father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. Rest Haven Cemetery 7-7-2008 Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 aitlin 23a. Part1. Enter the disease, an implication of the state of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HRS PULMONARY HEMORRHAGE Due to (or as a consequence of) DISORDER NEUROLOGIC UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner PREMATURE burial-trar Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Dav Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes

Physician /Medical Examiner

Saltimore, Maryland 21215-0036

Completed by Be Medical Certification: To Director:

Physician: The law requires that the death certificate be executed

م

Division or Vital Records,

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Hospital or Attending

State Registrar 31. Date filed (Month, Day, JUL 0 7 2008

Jah

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

HOL

DHMH 17 Rev 1/2001

After

death.

within 24 hours a To the Funeral L

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	Dhusisi		Regist 1. Deceden	nt's Name (First, Middle, Last)	1			2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio		()	scar litu		nce	Town or Location of Double	06	23	2008 Jounty of Deat	
	Examir	ner		Name (If no institution, give's	i Medical	Center Con	Annapolis			hne	Arundel
	Funeral		5. Social Se	ecurity Number 6. Sex	7. Age (In yrs.	Months	er 1 Year If Under 24 Hrs.	8. Date of Birt (Month, Da	h y, Year)	Co	hplace (State or Foreign buntry)
	Director		N/	A dence of Decedent	W ZUF D	Yrs.	05	106,2	3.2α	28 M	aryland
	yland		10a. State	10b. County	10c. Ci	ty, Town or Location					10d. Inside City Limits 1 XYes 2 No
	Be-1 e	ctor	MI) Anne A	rundel 1	asadeno			10a Citia	en of What Co	<u> </u>
	with the	Funeral Director	10e. Street	and Number Winding Wi	vote lila		ip Code 2 1122			SA	, and the second
	deeth	nera	11. Marital		12. Was Decedent Ever in U Armed Forces?	-	edent of Hispanic Origin? (Secify Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.)		4. Race - Ame Black, Whit	
36	within 72 hours after deeth with the Maryland ane. then "naturel", or iteme 23a or 28e-f ehow is Madical Examilier; and be notified at	by Fu		ver Married 2☐ Married dowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	× 1		-	Specify:	Thitz-
215-0036	2 hour	ted t	3 3 111	15. Decedent's Educ	cation	16a. Decedent's Us	ual Occupation ork done during most of wor	rkina	16b. Kin	d of Business	Andustry
215	within 7 ene. then "n ne Med	Completed	Elementa	(Specify only highest grade ary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)	All 19		N/A	
d 21	filed w Hygier Ather th		17. Father's	s Name (First, Middle, Last)		N/		ne (First, Middle,	Maiden S		
lan	ould be 1 Mental I arked o	To Be	1	egory David	1 Cerrenc	2	Melir	ida 5	ine	Lotz	-
Maryland	and and tem			nant's Name Rel Jonship (Typ	1 1	19b. Mailing Addres	ss (Street and Number or R	4 1	6		1 71127
-	1 end Health tem 27		20a, Metho	Uda Currence od of Disposition	Mother 206.1	Place of Disposition (N	ding woods h	Date Tas	20c. Loc	ation - City or	CT 1
mor	Pages nent of int: If it		1 □ Bo	urial 2XXCremation 3 Reconstion 5 Other (Specify)	emoval from State	cemetery, crematory or tro Cremato	1	, 2008	Ba.	Ltimore	, MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signat	we of Funeral Services icense		22. Name	and Address of Facility Ha	ardesty	Funeı	ral Hom	
	20129		220 Part	. Enter the disease, or complic	cations that caused the dea		gely Ave. Ar			21401	Approximate
J			shock	k, or heart failure. List only on Cause (Final	e cause on each line.	^	VER4	, , , , , , , , , , , , , , , , , , , ,			Interval Between Onset and Death
1	Physician /Medical		disease or resulting in		Due to (or as a consec		VELT				
	Examiner	_	Sequential	ly list conditions.	PREMAT	URITY					5 min
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o,	eath certificate be executed attending physicien and for use as the burial-transit			n death) Last	Due to (or as a consec	quence of):					
8760	cate by physic the bu	dicai									
Box 68	death certifica e attending ph of for use as th	n/Me	IF FEMALI	E: decedent pregnant	3c. If yes, outcome of pregn				2	3d. Date of de	
	0 0	sicia	in the	past 12 months? fes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown					Month	Day Year
P.0	hat the	Completed by Physician/Med		Jnknown er significant conditions con	tributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did t	obacco us	se contribute t	o the cause of death?
rds,	n signe	d by						1 🗆	Yes 2	X No 3□P	robably 4 Unknown
Records,	law requir es been si 2 should	plete						24a. Was	psy	prior to	utopsy findings available completion of cause of
E B		Con						1 ☐ Yes	2X No	death? 1 ☐ Ye	s 2 🕱 No
Vital	Physician: this certific ral director,	To Be	25. Was ca examin 1 \(\subseteq \text{ Ye}	H	ospital: 1 X Inpatient 2	☐ ER/Outpatient 3☐ [Other	ath <i>(Check only o</i> Home 5 ☐ Resi		□Other (Spe	ecify)
υot	0 - 0		27. Manne	r of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury	occurred	
Division	Attending r death. ector; After by the fune	catle	2 □ Ac	cident investigation		M	1 Yes 2 No	28f Location /	Street and	1 Number or F	Rural Route Number,
DİVİ	after of Direct In by	Certification:		omicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fact ify)	ory, onice	City or To			
	To the Hoepital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C		ck only 2 ☐ Medical Examin	iciant To the best of my kn ner: On the basis of examin	owladge, daath occurration and/or investigation	od at the time, date and clan on, in my opinion, death occ	a and dua to the urred at the time,	causa(s) date and	and manner a place, and du	s stated. e to the cause(s)
	thin 24 thin 24 the F	Medi	one) 29b. Signa	ature and title of certifier	and manner stated.		9c. License number				nth, Day, Year)
	8 1 £ 1		•	Mill!	Kerke		D31062	B-1-0-0	6/1	24/0	E
				and address of person who co		m 23a) (Type, Print)		1		•	
				Repka, M.D. 2	003 Medical 1		olis, MD 2140	1			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Day 2008 Francis

4b. City, Town, or Location of Death

June 30,

4c. County of Death

11:45 a M

Physician /Medical Examiner For State Registrar

James

Costello

4a. Facility Name (If not institution, give street and number)

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm M. d.c.al Evariner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

80/08/90

07731500

Suburban Hospit	a	- A		B	ethesda Year If Unde	0411	1		ontgo	omery	
	S. Sex MAM 2 ☐ F	7. Age (In yrs. 69		If Under 1	Days Hours	Min.	8. Date of Bi (Month, D	ay, rear;		Counti	
057-32-8267			1,0.				Sept.	13,	1938	New	York
Usual Residence of Decedent		10.0									
10a. State 10b. County		10c. Cr	ty, Town or Loc	ation						10	d. Inside City Limits
Maryland 1	Montgome:	ry	Mon	t.aome	ry Vill	age					1 □Yes 2X No
10e. Street and Number				10f. Zip Co		u g o		10g. Cit	izen of Wh	nat Counti	ry?
19809 Greensid	de Terra	ce			20886			U	SA		
11. Marital Status	12. Was Dece Armed Fo	dent Ever in U	.S. 13. W	/as Deceden	t of Hispanic O Cuban, Mexica	rigin? (Sp	ecify Yes or N	0-	14. Race		
1 ☐ Never Married 2 🕱 Married	d ty∏x Yes	2 No	Į.		_		Hican, etc.)			White, et	
3 Widowed 4 Divorced	If Yes, Giv Year or D	ve ates:1961-	-69	□Yes 2⊡	No Specify	r.			Specify:	wnit	е
15. Decedent's (Specify only highest of			16a. Decede	ent's Usual C aind of work of	Occupation done during more retired)	st of work	ing	16b. K	ind of Busi	iness/Indu	ıstry
Elementary/Secondary (0-12)	College (1 5 -	-4or 5+) +		Engine	·			G	overn	ment	
7. Father's Name (First, Middle, La	ist)				18. Moth	er's Name	e (First, Middle	. Maiden	Surname)	
Timothy Costell	lo						ıleen G		,		
19a. Informant's Name/Relationship	(Type. Print)		19b. Mailing	g Address (S	treet and Numb	er or Rur	al Route Numi	ber, City o	or Town, S	tate, Zip (Code)
Donna M. Costell	lo/Wife		19809	Green	nside Te	errac	ce, Mon	tgom	ery V	7illa	ge, MD 20
20a. Method of Disposition		20b. F	Place of Dispos cemetery, cremi				Date		ocation - C		
1 Burial 2 Cremation 3							Ly 3,				
4 □ Donation 5 □ Other (Spec		ме			remator		800	Ale	xandr	ria,	Virginia
1. Signature of Funeral Service Lic	ensee		22. Fr	Name and A	ddress of Facil	ity 1 i n a	Funomo	7 110	T	_	
& alance	o Domes	20-	50	O Unit	zersity	Blvć	runera I. W.	Silv	me in	ıc. rina	, MD 2090
3a. Part 1. Ent withe disease, or co	mplications that ca	aused in deat	h. Do not ente	r the mode o	f dving, such as	s cardiac	or respiratory	arrest	CI DD		Approximate
snock, or neart failure. List on	ly one cause on ea	ach line.			. ayınıg, oasın a	o our arao	or reopiiatory t	a,,,,			nterval Between Onset and Death
mmediate Cause (Final disease or condition	- 0.000										
	, Respi	ratory	Failur	e							2 weeks
		ratory or as a consequ		е							2 weeks
	Due to (or as a conseq	uence of):		228						
resulting in death) Sequentially list conditions.	Due to (or as a consequence of the conse	uence of): tructiv		nonary 1	Disea	ıse				2 weeks Decades
resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of): tructiv		nonary I	Disea	ıse				
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State

Registrar

10605 Concord Street, Kensington, MD 20895

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

egistrar's Signature

Steven Kariya, MD 31. Date filed (Month, Day, Year)

JUL 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JUNE 30 Day 2008 Year 20:04 PM **Physician** KESLER CAPLE, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 07–26–1937 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral №**М 2∏ F Lilesville,NC 246-52-5868 Yrs. 70 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f sho notified a 1 Ø Yes 2 □ No Capitol Heights Maryland |Prince George's Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or Items 23a or dical Examiner must be USA 20743 704 Clovis Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2€ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black ٥ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) D.C. Government Welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Flood McCray Kesler Caple, Sr. ပ 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 704 Clovis Avenue Capitol Heights, MD 20743 Annie Caple/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 07-09-2008 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signature of Fungral Service Lidensee 22. Name and Address of Facility Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascalas DISeaso Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-trans Due to (or as a conséquence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? 1☐ Yes 2☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1 Yes 2 No funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P☐ER/Outpatient 3☐ DOA 1 Inpatient P After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature nd title of ceptifier person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of aw 235 31. Date filed (Month, Day, Year) 32. Registrar's Signa State JUL 0 7 2008 Registrar

DHMH 17 Rev 1/2001

Nestor Santiago Catalan

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State of Maryland / Department of Health and Mental	Hygiene		
Certificate of Death	Reg. No.	200	
, Middle,Last)	2. Date of Death Month Day	Year	S-Tin

oto: Gartiago	_	Registrar	cate of Death	Reg	No. 2008 2322
Physicia	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year 1032 hrs
edical Exami		Nestor Santiago Aguirre Catala 4a. Facility Name (if not institution, give street and number)	1 4b. City, Town, or Loca	July 6, 2008	4c. County of Death
		6013 37th Avenue	Hyattsville	2040	Prince George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi			(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director		none 1XM 2 F 20	Yrs. Months Days I	Hours Min. Feb. 28	8, 1988 Guatemala
ru y		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
nd show :	٦	Md. Prince George's Hy	attsville		1 X Yes 2 No
Maryland 28a-f show any d at once.	ect	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
the N Ra or 3	ä	6013 37th Avenue	20782		Guatemala
D 21215-0036 should be a should be a should be filed on the Maryland and Monda I Hygien with 172 hours after death with the Maryland and Monda I Hygien was a should be a should be a should be should be should be sould be sould at once,	Funeral Director	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
after d al", or	by Fi	Widowed 4 Divorced If Yes, Give Year		oecify: Guatemalan	Specify: White
ours a	be be	15. Decedent's Education (Specify only highest grade completed) 16a	 Decedent's Usual Occupation (during most of working life. DO 		16b. Kind of Business/Industry
36 n 72 h uan "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Date .		O A Company The
withingiene	E O	7th 17. Father's Name (First, Middle, Last)	Painter 18.N	Mother's Name (First, Middle, M	O.A Contractors Inc. aiden Surname)
21215-0036 und be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be C	Santiago Aguirre		Sara Catalan	
21; ould b d Men s mar ife eve	2	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street an	d Number or Rural Route Numb	per, City or Town, State, Zip Code)
B, MD and 2 sh Health an item 27 i			6013 37th Ave.	Hyattsville, N	Maryland 20782 20c. Location - City or Town, State
ore, es lar of Her If itel			atory or other place)	Bate	200. Education - Only of Towns Grand
Baltimore, MD sernit Pages I and 2 sh Department of Health and Important: If item 27 is njury or other traumat		4 Donation 5 Other Specify: Fami	ly Cemetery 22. Name and Address of I		Peten, Guatemala
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiers Important: If iten 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Signature of Funeral Service Licensee Baconcc34	3447 14th S	treet. N.W. Wa	FUneral Home, Inc. shington DC 20010.
Physician /Medical		23a. Part I. Enter the disease, or complications that caused if e death. Do failure. List only one cause on each line.	not enter the mode of dying, suc	th as cardiac or respiratory arre	st, shock, or heart Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Asphyxia Due to (or as a consequence of):			Dodin
		b			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
	Examiner	(Disease or hijuly that in thated events resulting in death) Last Due to (or as a consequence of):			
recuted		d			
), be en siciar urial	Medical	UNPENDED AMENDED			
		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth		Ectopic pregnancy	23d. Date of delivery Month Day Year
Sox 6876(death certificate ne attending phys	sician/	past 12 months? 4 Pregnant at time of death	5 Other (Specify)		
	Phys	Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resul	ting in the underlying cause give	n in Part I 23e. Did to	bacco use contribute to the cause of death?
Records, P.O. Box 68: The law requires that the death certifit are has been signed by the attending sage 2 should be detached for use as:	호	Part II. Other significant conditions — contributing to death but not resor	and in the underlying cause give		2 No 3 Probably 4 Unknown
ords, I				24a. Was a	
Records, The law requir ficate has been s	Completed			autop	med? death?
		25. Was case referred to medical	26.Place of	1 Yes :	2 No 1 Yes 2 No
of Vital ng Physician: After this certi	Be	examiner? Hospital: 1 Innatient 2 FR			Residence 6 Other: Scene
n of V ling Phy After th funeral of	2	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month Day Year) 28	b. Time of Injury 28c. Injury a	28d. Describe h	now injury occurred
ion fendin eath or: A	[.	Pending	DUND: 1 Yes	2 V No	
Division of Vital I be priviled to Attending Physician: hours after death moreal Attractor: After this certification by filled in by the funeral director,	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home	, farm, street, factory, office build	or Town, S	Street and Number or Rural Route Number, City tate)
ie on	Çe	4 Homicide determined (Specify) Single Family			enué , Hyattsville, MD
E 4 E 9	ical	(Check only one) 2 Medical Examiner: On the basis of examination and/o	death occurred at the time, date or investigation, in my opinion, de	and place, and due to the caus eath occurred at the time, date	and place, and due to the cause(s)
To the I	Medical	and manner stated. 29b. Signature and title of certifier	29c. License n		29d. Date signed (Month, Day, Year)
(2)		Carol Haller	O.C.M.	E.	July 7, 2008
		30. Name and address of person who completed cause of death (Item 23.			
R			1 Penn Street, Baltimore	e, MD 21201	
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	lands .		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 1 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Lyril Crocker, Sr 1:47 AM **Physician** 30 2008 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomeri Washington Park Takoma Adventist 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours &9 Yrs. 364 22 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 DYES 2 No MD Montgomeru Takoma Park Funeral Director 10g. Citizen of What Country? 10e Street and Number united States 20912 1600 Hammond 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 1 1 No Specify: Black ģ 3 ☐ Widowed 4 Doivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Howard university Elementary/Secondary (0-12) College (1-4or 5+) nysician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Lillian Lawrence Crocker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7600 Hammond Ave Takoma Park, MD 20912 permit. Pages 1 and 2 and Department of Health an Important: If Item 27 is any Injury or other trau Patricia Crocker Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 07/03/2008 Riverdale, MD 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chambers Crem. 5 Other (Specify) 22. Name and Address of Facility John I. Rhines Funeral time 14 Signatur of Funeral Service License 3005 12th St. NE Washington, DC 20017 Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, mmediate Cause (Final disease or condition resulting in death) Due lo (or as a consequence of **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed sician and burial-tran Box 68760. physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 performe death? 1 ☐ Yes 2 ☐ No Heart certificate 25. Was case referred examiner? 26. Place of Death (Check only one) Be Hospital: 1 pnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A pompletely filled in by the fu 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year, JUL 0 8 2008

Lango

32. Registrar's Signature

1701

Carroll Ave

Takoma

CHALE 2

08-05003 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

K UNK	1.	St.	ate of Maryl	and / Depa <i>Cer</i>	rtment of tificate of	Health as Death	nd Menta	al Hygi		g. No	20	08 2322
Physicia		egistrar I. Decedent's Name (First, Middl	e,Last)					1.7	Date of Deatl	h Day Ye	ear	3. Time of Death 1939 hrs
diçal Examir	ner	Cristina Eliz	abeth Gar		<i>r</i> ez			J	une 28, 2	008 4c. County	of Death	1939 185
Marine.	4	a. Facility Name (if not institution		iumber)	4	b. City, Town, Ridge	or Location of	Death		St. Mar		
		48899 Bay Forrest Ro		7. Age (In yrs. I	ast birthday)	If Under 1 Y	ear If Under	24Hrs. 8	. Date of Birt	th(MM/DD/YYY	Y) g. Birth	nplace (State or
Funeral Director	,	5. Social Security Number None	6. Sex		Yrs	Months D	ays Hours	Min.	12/09	9/1986	Foreigr Cou	n IntryGuatemala
	.	Usual Residence of Decedent	1 M 2-1									10d. Inside City Limits
any		10a. State 10b. County			, Town or Locati						İ	1 X Yes 2 No
	٦	Md St.	Mary's	Lex	xington				- 11	0g. Citizen of V	What Coun	**
daryland 28a-f show d at once.	Director	10e. Street and Number	D -1 ***-			10f. Zip Code 2065			['	Guate		,
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. Ked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.		45806 Langley		Y ecedent Ever in U	16 13 Ws	os Decedent of	Hispanic Origi	in? (Spec	ify Yes or No			can Indian, Black,
th wit	meral	11. Marital Status 1 X Never Married 2 N	Married Armed	Forces?	If Y	es, specify Cul	an, Mexican,	Puerto Ri	can, etc.)	W	nite, etc.	~
	ᆲ		1 Yes				No specify:			Specif		ispanic
urs aft tural' amine	ğ	15. Decedent's Education (Sp.	or Dates:		16a. Deceder	nt's Usual Occu	pation (Give k	ind of wor	k done i)	16b. Kind of	Business/I	Industry
5 72 ho n "na	ē	Elementary/Secondary (0-12 9th) College	(1-4 or 5+)						Fact	Food	9
9036 within iene. er tha	Completed				Wai	tress	18.Mother	s Name (F	irst, Middle,	Maiden Surna		<u> </u>
21215-0036 Unid be filed within 72 hours after Mental Hygiène. marked other than "natural", ic event, the Medical Examiner	ابه	17. Father's Name (First, Middle Manuel Garcia					Jos	efina	a Chav	ez		-100m (4-41)
	9 B	19a. Informant's Name/Relation				ng Address (S						
MD d 2 shot lith and n 27 is sumation		Zaida Garcia	Chavez/S	ister					, Lex	ington	Park on - City or	Md 20653
imore, N Pages I and nent of Healtl ant: If item or other trau	35	20a. Method of Disposition 1 X Burial 2 Cremati	on 3 Remova	I from State	. Place of Dispo crematory or o	ther place)				1		
Pages nent of ant; I		4 Donation 5 Other	Specify:		General				08/08		atema	
Baltimore, MD 21 permit Pages I and 2 should Department of Health and Mt Important: If item 27 is an injury or other traumatic e		2. Signature of Funeral Service	rigensee			Name and Add		Mas Rive	son Fu erdale	neral S	Servi 20783	ces 5801
		23a. Part I. Miter the disease,	or complications that	at caused the dea	th. Do not enter	the mode of dy	ing, such as o	ardiac or	respiratory a	rrest, shock, or	heart	Approximate Interval Between Onset and
Physician Medical		failur. List only one caus	se on each line.									Death
aminer		Immediate Cause (Final disea or condition resulting in death		as a consequence	of):							
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	ine	if any, leading to immediate	e c.									
d sit	Examiner	(Disease or injury that initiated events resulting in death) Las	t Due to (or	as a consequence	e of):							
be executed ician and urial - transit	dical E	UNPENDED	dAMEND	ED .								
	ğ			es, outcome of pr	regnancy						te of delive	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physical to the funeral relative for use as the but the clinical by the change in the pure of the former of the control of the set of the but the change of the control of	sician/Me	23b. Was decedent pregnant in past 12 months?	n the 1 L	ive birth	2	Fetal death		ic pregna	ncy	Mon	ith	Day Year
ox 6 ath cer attendi	Sicis	1 Yes 2 No 9		regnant at time of Inknown	death 5	Other (Specify)					
O. BO) that the deatl ned by the att detached for	P	Part II. Other significant cor		ing to death but no	ot resulting in th	e underlying ca	use given in F	Part I.				to the cause of death?
, P.O.	<u>۾</u>									Yes 2 ✓ No		robably 4 Unknown
ords, F v requires s been sign should be	Completed by									itopsy	prior t	autopsy findings available to completion of cause of
COF e law r e has b	2									erformed? es 2 No	death	
tal Rections The certificate	ျှင်		dical			26	Place of Deat					
Vital Rec ysician: The l his certificate l	To Be	examiner?	Hospital: 1	Inpatient 2					ng Home 5	Residence		her: Scene
vision of Vortending Phyficer death.	ē ⊢		100	Date of Injury Month, Day Year) 128, 2008	28b. Time 1930 hrs	. , ,	c. Injury at Wo		Occupan	t auto fixed	object of	collision
Sion Attendig death.	j ,	1 Natural 5 F	ending	Place of Injury - A		l l			28f. Location	on (Street and	Number or	Rural Route Number, City
Division of Vital Records, ria or Attending Physician. The law require rs after death. By Director: After this certificate has been sind in bring the strength of the strengt	Certification:	3 Suicide 6	could not be	. Place of Injury - / ec <i>ify)</i> Local S		street, factory, t	mice banding,	O.C.	or Tow 48899 Bay	m, State) / Forrest Roa	ıd, Ridge,	, MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire	S La	4 Homicide 29a. Certifier	7.7		dedes dooth o	ccurred at the t	me, date and	place, and	due to the	cause(s) and m	nanner as s	stated.
the Horizontal	Modical	(Check only one) 2 Medical	Examiner: On the b	pasis of examination of stated.	on and/or invest	tigation, in my	pinion, death	occurred :	at the time, o	iate and place;		
To With		29b. Signature and title of ce	ertifier	nier stateu.		29c.	License numb	er		1		(Month, Day, Year)
		Miller A.	a well	MA			O.C.M.E.			June 2	29, 2008	
10 10		30. Nam- and address of pe		d cause of death ((Item 23a)	1 Penn Str	not Daltim	ore Mr	21201			
12 4		Melissa Brassell, N		t Medical Exa		1 Penn Str	et, Baitim	ore, ML	, Z 1ZU I			
	Stat	e 31. Date filed (Month, Day 2	ear)	32. Registrer's Sig	1	•						

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			FoAmend Item 10f. S 1- RegistraWCHD/SH 7/8/0	State of Marylar 8 per FH	nd / Depa <i>Cer</i> i	rtment of H	ealth and M Death		gien 2 0 0 8	23224
	8		Decedent's Name (First, Middle, Last)					2. Date of Dea	ith	3. Time of Death
H	Physicia /Medic	al	David Distin 4a. Facility Name (If not institution, give str	eet and cumber)		Ab City Town or	Location of Death	July	Day Year 2008	
	Examin	er			0.5				Washing	
	Function		11 Walnut Stree 5. Social Security Number 6. Sex	ot APT. 3		Hagers	If Under 24 Hrs.	8. Date of Birtl	h 9. Bi	rthplace (State or Foreign
n.	Funeral Director			1 2□F 44	Yrs.	Months Days	Hours Min.	5/21/6		ountry)
			Usual Residence of Decedent					0/22/0		
	nylan how		10a. State 10b. County	10c. Ci	ity, Town or Loc	ation				10d. Inside City Limits
	e-f.	cto	Md Washingto	on H	agerst	own				1 TYes 2 □ No
	or 26	Director	10e. Street and Number		-7	10f. Zip Code	217		10g. Citizen of What C	ountry?
	23a		11 Walnut Stre			2174	-		USA	
	ep .	Funeral	11.10.2.10.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0	Was Decedent Ever in U Armed Forces?	J.S. 13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	or if	F.	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1	☐Yes 2XNo	Specify:		Specify: W	hite
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23e or 28e-f show the Marical Exercities, must be rectified at	d by	3 Widowed 4 Divorced	Year or Dates:	16a Dagad	ent's Usual Occupa	rtion		16b. Kind of Business	Andusta
5	"nai	Completed	15. Decedent's Educa (Specify only highest grade of		(Give)	and of work done of NOT use retired	furing most of work	ing	TOD. KAIG OF DUSINOS.	amoustry
7	withi ene. then	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		Meta1			Constru	ction
9	filed Hygi ther ant,		17. Father's Name (First, Middle, Last)		Direct	rictar		e (First, Middle,	Maiden Sumame)	001011
Maryland	spes 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other then "naturel", or iteme 23a or 28e-f show or other traumatic event, the Madical Expandent man Kernolling at	To Be	Thomas W. Disti	n			Lillian	Berni	ce Hensl	ey
₹	shoul nd Mari mari	Ĕ	19a. Informant's Name/Relationship (Type		19b. Mailin				r, City or Town, State,	
Š	ith ar 1th ar 27 is 1trau		Lillian Distin (Mother)					hsburg, M	
ē,	Health tem 27 other tra		20a. Method of Disposition	20b.	Place of Dispos	ition (Name of		Date	20c. Location - City o	
20	ages ant of it: If i		1 X Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	-	atory or other place morial F	$\frac{\pi}{2}$ 7/10	0/08	Beckley,	TAT X7
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 eny injury or other once.		21. Signature of Funeral Service Licensee	Би	1	Name and Address	s of Facility			
Ba	Dermi Impo eny i		19mil / Steller	MA # 1035	- 50	El Daba	B1	ue Rid	ge Funer	al Home
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			shock, or heart failure. List only one Immediate Cause (Final	cause on each line.						Interval Between Onset and Death
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m	thet the death cer ed by the attendin detached for use	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)			Month	Day Year
P.O.	t the by th tache	hys	9 ☐ Unknown	9 Unknown						
	es the igned be dei	by P	Part II. Other significant conditions contri	buting to death but not re	sulting in the un	derlying cause give	en in Part I.	23e. Did to	obacco use contribute	
ğ	w require s been sig should b	edt						1 🗆 Y	res 2⊠No 3∏F	Probably 4 Unknown
S	s bec	bet						24a. Was	an 24b. Were a	autopsy findings available completion of cause of
æ	The I	Completed						perfo	rmed? 📜 death?	s 2 No
ta	an:	0	25. Was case referred to medical				26. Place of Deat			
Division of Vital Records,	Attending Physician: r death. ector: After this certification of the funeral director.	To B	examiner? 1 Tyes 2 No	spital: 1 Inpatient 2	ER/Outpatient	3□ DOA Othe	er: 4 Nursing Ho	me 5 Resid	dence 6 Other (Sp	ecify)
0	g Ph ter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	/ at	28d. Describe h	now injury occurred	
Ö	ath. r: Af	atlo	2 Accident investigation		, ,,,,,,		Yes 2 □No			
<u>Xi</u> S	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Number or I vn. State)	Rural Route Number,
۵	tei or rs efte at Dir	Cer								
	To the Hospitei or Attending Physician: The lav within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		ian: To the best of my kn r: On the basis of examin						
	To the H within 24 To the F complete	led	one)	and manner stated.				-		
	5 vit	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed (Mor	ini, Day, Teal)
ı			" Muchael M	Moral	MO	D	4166	7	1.4	08
4			30. Name and address of person who com		m 23a) (Type, I	Print)	rdical		i.J	erstown Mo
	スート		Michael /N	Cormack Sing		0 /n	ed ical	can	nus lucis	ers/own 141
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.2 | | | | | | | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY 6, 2008 Harry James Durst 5:00A. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Cumberland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | March | 2, 1949 | Pennsylvania Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2□ F 59 214-52-1317 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17707 Buckley Rd. 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕱 No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Owner/Operator Trucking 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Durst Bertha Ours 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17707 Buckley Rd., Cumberland, MD Elizabeth M. Durst/Wife 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Durst Cemetery July 9, 2008 Grantsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Line euma - X P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebral Emboli Stroke Mulyte Due to (or as a consequence of): iralion if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Dehy denlivin Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1□ Yes 2 X No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 XInpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner P.O. Box 68760

Physician

/Medical

Examiner

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natures" any hinry or other traumatic events.

Exami the burial-tran Physician/Medical attending ph ed by the a detached f signed b page 2 should certificate has director. Certification: To After this funeral 24 hours after death e Funeral Director: filled in by

Division or Vital Records,

Hospital or Attending Physician:

the

death.

within 24

þ Completed Be 27. Manner of Death 1 Natural

3 Suicide

29a. Certifier

4 Homicide

(Check only

2 Accident

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 TYes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

and manner stated

29c. License number D0066070 29d. Date signed (Month, Day, Year) 7/08

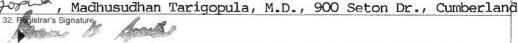
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tarigope Madhisidhen

MD, 21502

State Registrar

Medical

31. Date filed (Month, Day, Year) 8 2008 JUL



23226 Amend Item 26 per dr. 2881.07/31/08dhb Mental Hygien 0 0 8 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year July 3,2008 Μ. Dorman 6:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lee's Almost Home Ocean City

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Wonths | Days | Hours | Min. | (Month, Day, Year) Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F 93 Director 215-14-3300 17,1915 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Exactiver itsust by notified at 1X Yes 2 No Director MD Worcester Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 307 N. Main Street 21811 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home . c., Marylant.
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Department of Health and Menter.
Important: If Itsm 27 Is—
any Injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0nlev Eugene Amy Myrt1e Bailey Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wm. Thomas Dorman, Jr. - Son 307 N. Main Street Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Phillips Cemetery 7-7-2008 Quantico, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licenses 705 E. Main Street Salisbury, MD 21804 23a. Part Linter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) serile demantia **Physician** /Medical Examiner stearthritis Sequentially list conditions, if any, leading to infiltediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760, physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Ö detached 9□ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 3 Probably 2 No 4 DUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan hes autopsy performed? (es 2 Solo 2 No 1 ☐ Yes 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Nother (Specify) LIVING Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 2 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred After Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No I Director: And in by the f 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a nd tiple of certifie 824 30. Name and address of perso impleted ause of death (Item 23a) (Type, Print) mp 13111 (Month, Day, Y 31. Date filed Year) Registrar's Signa State 7 2008 Registrar

mended Item	n #/	23c per Physic: Pleas	se Type or	Print in B								
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Physicia /Medic		1. Decedent's Name (First, Middle	E.	Dye				2. Date of De Month	Day 28	Year 208	3. Time of 2 %	
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Director		215–14–6410 Usual Residence of Decedent 10a. State 10b. County	1□M 2 ⊠ F	87	Yrs.	Months Days	Hours Min.	sept.	25°1920		yland Od. Inside C	ity Limite
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Marical Examiner must be notified at once.	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12) unknown	's Education tt grade completed) College (1	1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired IEMAKET	oation during most of wor d)	rking	House	Business/Inwork	dustry	
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Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled.	tion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 27. Manner of Death 1 ☐ Matural 5 ☐ Pendin 2 ☐ Accident investig	28a. Date (Mon		ER/Outpatie 28b. Time o Injury	Wor	ner: 4 🗆 Nursing I	ath (Check only Home 5 Res 28d. Describe			ify)	
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Sta		30. Name and address of person Palman A. 31. Date field (Month, Day, Year))anai	se of death (Item M - D - Registrar's Signat	1282		H:II A	ive., H	ayerst	eve,	MD	217
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Maryland 21215-0036	de F F	Ĕ	19a. Informant's Name/	/Relationship (T	/pe. Print)		19b. Mailir	ng Address (Stree	t and Nur	nber or Rura	al Route Numb	er, City o	or Town, State, Z	ip Code)	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 Day 2008 Year **Physician** JULY 10:00 AM DEYOUNG NORMA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JAN • 17 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Min 1936 1 □ M 2 🔀 F GUYANA 72 Director 220-53-1109 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No PRINCE GEORGE'S MITCHELLVILLE MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be USA 20721 2802 EDSON COURT Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2K Married BLACK Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If Item 27 is marked other tha any injury or other traumatic event, the Jonce. PRIVATE HOUSEWIFE 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LILLIAN WOOD WILLIAM BURROWES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2802 EDSON COURT MITCHELLVILLE, MARYLAND 20721 19a. Informant's Name/Relationship (Type. Print) SANDRA DEABREU/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GEORGETOWN, GUYANA LAREPENTIR CEMETERY 7/10/2008 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Right Basilar Cerebrovascular Extensive / WK /Medical Due to (or as a consequence of) Examiner Lety er tension
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed Due to (or as a consequence of): Diabetes and burial-tran Box 68760, physician Physician/Medical the as attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the Records, P.O. detached 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 2 No 3 Probabiy 4 Unknown reprovascula 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy The certificate 28 No 1□ Yes Division or Vital Physician: 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 201 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA မ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 24 hours after death. 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

JUL 0 7 2008

31. Date filed (Month, Day,

30. Name and address of person who comp

ortal 1500 Forest Glen Rd. Su pant Day, Year)

eted cause of death (Item 23a) (Type, Print)

D0065485

RSM MO

		1 - For State Registrar AMEN)#4aperMD	State o 7-3-08,B	of Maryland		artment of tificate o				iene g. 160.	08	23230
	siciar ledica	Decedent's Name (Fig. 1)	irst, Middle, Las	ing Fong						2. Date of Dea Month June	Day 25	Year 2008	3. Time of Death 3:45 p _M
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Fune Direc	-	5. Social Security Numb 086-10-737	1 1	ex ⊠M 2□F	7. Age (In yrs. la 98	ast birthday) Yrs.	If Under 1 Year Months Day		Min.	8. Date of Birth (Month, Day May 16	, Year)	9. Birth Cou	place (State or Foreign ntry) China
e Maryland	Director		b. County Montgo	nery	10c. City	, Town or Lo	cation	Bethes	da				10d. Inside City Limits 1 ☐ Yes 2X No
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Hema 23a or 28a-f show	injury or other	20a. Method of Disposit 1 ABurial 2 C 4 Donation 5 C 21. Signature of Finera	ion remation 3 Other (Specify	Removal from	State	ace of Dispo emetery, crem rge Wash	sition (Name of natory or other paington Ce	emetery	07/0		20c. Location Adelphi	- City or T	own, State
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Physici /Medi Examir	cal	disease or condition resulting in death)	(Due to	thmia (or as a consequardial Ind		n						5 minutes 5 minutes
cate be executed physician and the burial traceit	burial-transit	Sequentially list conditi if any, leading to immediate. Enter Underlyin Cause (Disease or injurt that initiated events resulting in death) Last	g g y	Due to	(or as a consequent of the consequence of the conse	mbalance	9						greater than a week
death certiff attending	use as	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 Yes 2 No	iths?	1□Live i	tcome of pregnar birth 2 Fetal nant at time of de own	death 3	Ectopic pregnar Other (specify)					ate of delive	rery Day Year
S, P es that gned b	P 2	Part II. Other significan	at conditions c	ontributing to d	eath but not resu	liting in the ur	nderlying cause	given in Part	1.		bacco use cor		the cause of death? bably 4544nknown
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n of ng Phys fter this	inneral Floor	examiner?	☐ Pending investigation	28a. Date (Mon		ER/Outpation 28b. Time of Injury	28c. In	Other: 4	sing Ho	n (Check only or me 5 ☐ Resid 28d. Describe h	ence 6 □Ot		(fy)
DIVISION I or Attending after death. I Director: After	o in by the lunera	3 Suicide 6 4 Homicide	Could not be determined	286. Place	of Injury - At hor ing, etc. (Specify,	me, farm, str	eet, factory, offic	е		28f. Location (S City or Town		ber or Rui	al Route Number,
To the Hospital or Atlandi within 24 hours after death. To the Funeral Director, A completely filled in the the results of the formulation of the following in the following in the following in the filled in the following in the filled in th	Medical Certifical		Gertifying Ph Medical Exam	niner: On the b	best of my know asis of examinati ner stated.	wledge, death ion and/or inv	occurred at the restigation, in my	time, date a y opinion, de	nd place, ath occurr	and due to the c ed at the time, d	ause(s) and mate and place	anner as and due	stated. to the cause(s)
O To the To the	dinos	29b. Signature and title	4	0.			DI	nse number	9		9d. Date signe 6-25		Day, Year)
	0.	30. Name and address Raman Rekh 31. Date filed (Month, D	a Tuli, N	I.D., 108	10 Darnes	town Roa	ad, Suite	202, G	aither	sburg, Ma	ryland 2	0878-2	2675
Reg	State gistrar		_	08	legistrar's Signat	1 Apr	enter						

State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death

2. Date of Death 1. Decedent's Name (First Middle Last) **Physician** Virginia Agnes Foster 2008 12:02AM Ju₁v /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 405 East D Street Frederick Brunswick 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2) F Director 52 Nov. 5, 1955 Washington, DC 217-68-5893 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Iteπs 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD 0akland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 United States 485 Boy Scout Road Funeral . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner & Operator Bar/Saloon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilda M. King Joseph A. Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. John Patrick Foster, Husband 405 East D Street, Brunswick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 7/5/08 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Garrett Memorial Gardens Oakland, MD 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A. 21. Signature of Funeral Service Licensee Sucitive Katherine 21 N. Second St., Oakland, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one contract of the contract Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) BREAST **Physician** METASTATIC MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the burial-tran Due to (or as a consequence of): attending physician Physician/Medical use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No ို 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

Division or Vital Records, P.O. Box 68760, within 24 hours a

> State Registrar

Medical

4 Homicide

(Check only

BRIAN

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL

29a. Certifier

determined

00

32. Registrar's Signature 2008

40

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



SOI W, SEVENTH

150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

031761

29d. Date signed (Month, Day, Year)

			For State Registrar	State o	f Marylar		artment o rtificate d				_	2008	23	1232
	Physici /Medic		1. Decedent's Name (First, Middle, L Heidrun Marlene	,						2. Date of Dea Month July 2	ath Day	/ Year		of Death
	Examir		4a. Facility Name (If not institution, gi 10130 Gary Road	ve street and nu	mber)		4b. City, Tow Potoma		of Death		Me	County of Deatl		
	uneral irector		212-13-0325	Sex 1□M 2ĂF	7. Age (In yrs.	last birthday) 4 Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Birl 01/29/	th 17 Yea <i>r)</i> 1944	9. Birtl Cor Gen	nplace (State untry) Cmany	or Foreign
d 21215-0036 filed within 72 hours after death with the Maryland	28a-f show ctified at	Director	Usual Residence of Decedent	nery		ty, Town or Lo								City Limits
ath with t	23a or 3	ral Dir	10e. Street and Number 10130 Gary Road				10f. Zip Coo 20854					rmany	antry?	
036 ours after de	or result and welfart hyberta hyberta and season states are show other traumatic event, the Madical Exeminer cast be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 AMarried 3 □ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1Yes If Yes, Giv Year or D	2Ă No ve		Was Decedent f Yes, specify (1 □ Yes 2 🛭			ecify Yes or No Rican, etc.)		14. Race - Amer Black, White Specify: White	, etc.	
Maryland 21215-0036 d 2 should be filed within 72 hours aft	r than "natu the Medical	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1 5H	-4or 5+)	16a. Dece (Give life.	dent's Usual Ockind of work do DO NOT use re	cupation ne during mo tired)	st of worki			nd of Business/I	ndustry	
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	27 Is ma er trauma		19a. Informant's Name/Relationship Juergen Franz /							al Route Numbe		r Town, State, 2	ip Code)	
imore Pages 1			20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☒ 4 ☐ Donation 5 ☐ Other (Spec	fy)	State Met	Place of Dispo cemetery, cren croppol	sition (Name of natory or other itan C1	ematon	y 7/:	2/08	20c. Lo Alex	cation - City or Tandria,	VA	
Balt permit.	Impor any In		21. Signature of Funeral Servic Lice	that								s Sons ston, DC		5
	rsician ledical		23a. Part 1. Enter the disease, or con shock of heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Mali	aused the deat ach line. .gnant or as a conseq	Mening		dying, such a	s cardiac c	or respiratory a	rrest,		Approxim Interval B Onset and	ate etween d Death
	aminer	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	or as a conseq									
8760, cate be executed	physician and the burial-transit	dical Examine	Cause (Disease or Injury that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):								
. Box 6	attending or use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ♣ No 9 □ Unknown		oirth 2 Feta nant at time of	ıl death 3 □	Ectopic pregn Other (specify				2	23d. Date of deli Month	very Day	Year
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The law	zate has page 2	Completed	12.17					2-21	4-52	24a. Was autop perfo 1 □Yes	osy rmeøl?	death?	opsy finding ompletion of 2 \(\sum \text{No}\)	s available cause of
Of Vital Physiclan: T		Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	npatient 2 🗆	FD/0-4-4-	4 0 17 1004	Othor:		(Check on o				
⊆ ∑	fter th	Certification: To	27. Manner of Death XXNatural 2 \sum Accident 5 \sum Pending investigation	28a. Date (Mont		28b. Time of Injury	28c. [njury at Vork?	2	28d. Describe h		6 ☐ Other (Spec y occurred	ary)	-
DIVISIO To the Hospital or Attendit within 24 hours after death.	ral Directo lled in by t	Certific	3 ☐ Suicide 6 ☐ Could not be determined	buildir	of Injury - At he					City or Tou	vn, State,			ımber,
the Hosp	To the Funeral Dir completely filled in	Medical	29a. Certifier 1	hysician: To the miner: On the ba and mann	asis of examina	wledge, death ation and/or in	occurred at the contract of th	e time, date a ny opinion, de	and place, ath occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause	o(s)
-			29b. Agnature and title of certifier	Late	ve.	mo	D3	7018				y 2, 200		
V			30. Name and address of person who John J. Lateria,	M.D. 6	600 Nor	th Wol		et Bal	timor	e, Mary	1ano	1 21287		
	Sta Registr		31. Date filed (Month, Day, Year)	18 See	egistrar's Signa	ture	S. S.							

DHMH 17 Rev 1/2001

Approximate Interval Between Onset and Death

day

Year

Were autopsy findings available prior to completion of cause of

2 □ No

Month

death? 1 ☐ Yes

efense they Crofton MO 21114

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show r 28a-f show notified at item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in Saltimore, Maryland 21215-0036 permit. Pages 1
Department of H
Important: If Ite
any in]ury or ot

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Director

Physician /Medical **Examiner**

signed by the attending physician and doe detached for use as the burial-tran should be To the Hospital or Attending Physician: within 24 hours after death,

To the Funeral Director: After this certifics completely filled in by the funeral director, f

After this certificate has been

Division or Vital Records, P.O. Box 68760

Funeral 11. Marital Status 1 ☐ Never Married 2KM Arried þ 3 Widowed 4 Divorced Completed (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Pinckney Alice Hines ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Grimaldi Spouse 1730 Urby Dr. Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 122 Burial 2 Cremation 3 Removal from State Gate of Heaven Cem 4 ☐ Donation 5 ☐ Other (Specify) 7/2/2008 Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. ()alsu 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a gonsecuting: of Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of Crtifier 29c. License number 29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 30. Name and add

31. Date filed (Month, Day,

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12^{Day} **Physician** July 2008 1615 РМ Sandra Mae Goddard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 Elkton 22 Augusta Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2\\F AUG 31. Delaware 52 1955 Director 217-64-4652 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Ceci1 E1kton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 United States 22 Augusta Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 ☐ Widowed 4 🎇 Divorced Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) 12 College (1-4or 5+) Postal Service Rural Mail Carrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Curtis Clay Dunn Ruby Phipps ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Pedrick/Life Partner 22 Augusta Drive, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 17, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. West Chester, PA 2008 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer-Meta Static **Physician** /Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed physician and is the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p 33 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, δ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed? page 2 s this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 | Inpatient Certification: To 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUL 1 8 2008

29b. Signature and title of certifier

Madhu Sachder

322 ec. 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

State of Maryland / Department of Health and Mental Hygiene 23235 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Ju1v 2008 7:00P M Glendora Lee Harvey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death Dennett Road Manor Nursing Home Oakland Garrett If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 218-68-4184 1929 Director 79 Mary land Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 📆 No Director MD Garrett Swanton 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 23a Zion Road 122 Mt. 21561 United States death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Ş 3

Widowed 4

Divorced White "natural", Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry perrat. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rayn jujury or other traumatic event, the Mad 2008. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma O'Haver Albert Dunithan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 283 Mt. Zion Road, Swanton, MD Dale Harvey, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 7/8/08 4 □ Donation 5 □ Other (Specify) Mt. Zion Cemetery Swanton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 710 Church St., Kitzmiller, MD 21538 Katherine 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician 3⅓ wks disease or condition resulting in death) cerebrovascular accident /Medical Due to (or as a consequence of): Examiner atherosclerotic cardiovascular disease yrs Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transi diabetes mellitus yrs Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 🏂 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Alzheimer's type dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate has 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Dther: Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2.1X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification; 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 07-06-2008 D30035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KM 0 Donald R.Richter, M.D. 1533 Memorial Drive Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2008 JUL Registrar

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Barbara Anne Hranicky 7:50 a M July 3, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Days 1 □ M 2 🖺 F Months Hours Aug. 8, 213-24-3798 76 1931 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2X No Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6804 Orem Drive 20707 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X N**O 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Homemaker Own Home

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

08-04812 Ernest T. Hayes		Please	Type of State	or Print in Bl of Maryland	/ Depar	lelible l tment o	f Healt	th and Menta	opies Are L al Hygiene	egible		<u> </u>	23	323
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Physician Medical Examin		Ernest Th							Month June 22		Year		1840 hrs	
Constitution		4a. Facility Name (if not in 5308 Hil Mar Dri		ve street and number)			4b. City, 1 Suitla	Town, or Location of and	Death		: County of D Prince Geo			
Funeral Director	- 1	5. Social Security Numbe $124-36-322$		ex 7. Ag X _{M 2} F 6	e (In yrs. las 1	st birthday) Yr	Month	er 1 Year If Under is Days Hours	24Hrs. 8. Date of Min. 12-0		00/11111 9 946	!	ace (State o y) NY	
ow any	Ī		County	Georges	1	Town or Loca		ghts					d. Inside Cit	,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	흸	10e. Street and Number 5308 Hil M					10f. Zip			10g. Cit	izen of What	Country	>	
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136 hin 72 hour te. than "natu	Completed	Elementary/Secondary	(0-12)	College (1-4 or		during	most of wo	rking life. DO NOT u Consulta	se retired)		helps			
215-0036 The filed within 77 The Hygiene. Red other than The Medical	Be Con	17. Father's Name (First, Ernest Tho	Middle, Las	t)	•				Name (First, Middle Young	e, Maider	Surname)		F-CEN DAZA	
MD 2121: d 2 should be fi lth and Mental I n 27 is marked aumatic event,	اع	19a. Informant's Name/R Veralyn Ha		•		19b. Maili 152	ng Address Hel	s (Street and Numb en St 2r	per or Rural Route I nd Fl.Ha	mde	n, CT	06	51 4	
JOFE, Nages I and nt of Health It: If item other trau	Ì		remation 3	Removal from S	tate cr	rematory or	other place	me of cemetery, (remator)	Date 07/07/08	.	Location - C iverd			
Baltimore, permit. Pages I an Department of He Important: If ite		21. Signature of Funeral			JICE V			Address of Facility Sons 563		st.	NE Wa	ashi	ngto	9018 8180
Physician /Medical		failure. List only on	e cause on	oplications that cause each line. Bypertensive A		Do not enter	r the mode	of dying, such as ca	rdiac or-respiratory	arrest, sh	ock, or heart		Approximate Between O Dea	nset and
^5 Examiner		Immediate Cause (Final or condition resulting in		Due to (or as a cons										
	xaminer	Sequentially list condition if any, leading to immedicause. Enter Underlying	ate Cause	Due to (or as a cons	sequence of):								
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be exercician a	dica	UNPENDED		AMENDED	_									
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be execute thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and appliedly filled in by the funeral director, page 2 should be detached for use as the burial - tran	sician/Medical	IF FEMALE: 23b. Was decedent pregi past 12 months?			ome of pregnat time of dea	2 🔲	Fetal death Other <i>(</i> S <i>p</i> :		pregnancy	. 2	3d. Date of d	elivery Day	,	Year
P.O. Bcss that the designed by the a	by Phys	Part II. Other significan		J GIRGIOWII	ith but not re	esulting in the	e underlyin	ng cause given in Pa		id tobacc Yes 2	o use contrib			
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by tuneral director, page 2 should be detach.	Completed								a	/as an utopsy erform <u>ed</u>	pri ? de	ior to cor ath?	osy findings npletion of c	cause of
Rec The l ficate h	Con			,				26.Place of Death (es 2	No 1	✓ Yes	2	No
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Division pital or Attendii ours after death.	ertification:	1 V Natural 5 2 Accident 3 Suicide 6	Pending Investig Could n	ation 28e. Place of	Injury - At ho	ome, farm, st	treet, factor	1 Yes 2 ry, office building, etc	c. 28f. Locati	on (Street	and Number	r or Rura	Route Nur	mber, City
Divisior o the Hospital or Attend rithin 24 hours after death o the Funeral Director: ompletely filled in by the	ပ	4 Homicide 29a. Certifier 1 Cert (Check only 1	determin	ician: To the best of er:On the basis of ex	my knowledg	ge, death oc	curred at th	he time, date and pla	ace, and due to the	cause(s)	and manner a	as stated	cause(s)	
To the vithin To the comple	edical	one) 2 Med	iicai Examir	er: On the basis of ex and manner state	ammation at	nu/or investi	gauon, mn	ny opinion, death oc	outrou at the time, t		Date signe			-)

State Registrar

29b. Signature and title of certifier

Jack Titus MD

30. Name and address a person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

June 23, 2008

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 23238 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 1951 M 2008 anree 3. Un /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9223 Sro Was er4 1 Mon 01 JOSHETY If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9 Birthplace (State of Foreign **Funeral** 1 □ M 2 🗓 F Months Days Min. Yrs 61 9/6/1946 Director 578-58-1414 Washington, DC Usual Residence of Decedent 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the fix dical Evant had a period of 10c. City, Town or Location 10d. Inside City Limits Director tX Yes 2 ☐ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9223 Frostburg Way 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurses Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental H 7 is marked ot Joseph W. Stephens Ruth S. Slade ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traunonce. Audrey Stephens/ Sister 1816 Timberlane Drive Flint MI 48507 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington 7/5/2008 Adelphi, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Part 1. Enter the disease shock, of heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 ME /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transi-Due to (or as a consequence of): Box 68760, certificate be Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a t be detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s autopsy page perfor this certificate of Vital 1 ☐Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After the 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death. filled in by the fr 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Direct To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and ignature and title of certifie 29c. License number

State Registrar

31. Date filed (Month, Day, Year) 32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** June 28,2008 Helen Marie Coulbourn Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbu Salisbury Rehaba Nursing Center Wicomica Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 XF Director 219-03-5005 94 May 21, 1914 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Wicomico Fruitland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 310 Morris Street Funeral 21826 **USA** American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 ☑ No Specify Completed by Specify: 3 Nidowed 4 Divorced Year or Dates Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic 9th MAC Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Elizabeth Horsey John R. Coulbourn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11951 Glen Circle - Bridgeville, Delaware 19933 Henry Jones/son Baltimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Domation 5 ☐ Other (Specify) Springhill Mem. Gdns July 5, 2008 Hebron, Maryland 22. Name and Address of Facility 1213 Jersey Road, Salisbury, M.D. 21. Signa ture JOLLEY MEMORIAL CHAPEL 21801 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** an eres 1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner the death certificate be executed that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the ending pt r use as t IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 → HO 3 □ Probably 4 □ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1□ Yes 3 DNO 25. Was case referred to medical examiner? director, 26. Place of Death Check onli one Certification: To Be Other: 4 Inversing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ №6 2 ER/Outpatient 1 Inpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 ☐ Pending investigation 1 ☐ Natural ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

29b. Signature and title of certifier

William H. Robin

31. Date filed (Month, Pay, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar DHMH 17 Rev 1/2001 29c. License number

ivic Ave.

29d. Date signed (Month, Day, Year)

.amar	Emmett Jackson	

-05120	Please Typ	oe or Print in	Black Inde	lible In	k. Ensure	All Cor	oies Are Legi	ble.			
mar Emmett Jack		ate of Maryla									
	1- For State Registrar		Certific	cate of	Death		Reg	No. 2	008	2324	+ 0
Physician/ edical Examiner	Decedent's Name (First, Middle LaMar English		ackson				. 2. Date of Death Month E July 3, 2008	oay Year		e of Death 53 hrs	
•	4a. Facility Name (if not institution 4400 Suitland Road	on, give street and nur	mber)	41	b. City, Town, or L Suitland	ocation of De	eath	4c. County of Prince Go			
Funeral Director	5. Social Security Number 578-94-6942	6. Sex	7. Age (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birth	MM/DD/YYYY)	9. Birthplace Foreign WAS Country)	hington, DC	
dow any	Usual Residence of Decedent 10a. State 10b. County Maryland Prin	ce George'	10c. City, Tow	n or Location					***	nside City Limits	

10f. Zip Code

20746

10g. Citizen of What Country?

United States

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh injury or other traumatic event, the <u>Medical Examiner must be notified at onc</u> permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylane Department of Health and Mental Hygiene.

Be Completed by Funeral Director

5210 Carswell Avenue #104

Baltimore, MD 21215-0036 Physician 'Medical

xaminer

×

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

	i i	cause. Enter Underlying Cause (Disease or injury that initiated
ransit	Exa	events resulting in death) Last
urial - t	edica	X UNPENDED
as the b	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
d for use	Be Completed by Physician/Medical Examin	1 Yes 2 No 9 Unk
ache	à	Part II. Other significant conditi
e det	by	Diabetes Me
ıld b	ted	
sho	əd	
page 2	Som	
ctor,	e C	25. Was case referred to medical
dire	0	examiner? 1 ✓ Yes 2 No
neral	<u> </u>	27. Manner of Death
he fu	ţ	1 X Natural 5 Pendi
by t	ca	2 Accident Inves
ed in	Ē	3 Suicide 6 Could
9	ပိ	4 Homicide
completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Certification: To	(Check only one) 2 Medical Exam
0	Me	29b. Signature and title of certifier

Theodore M. King, Jr., MD

31. Date filed (Month, Day, Year

Pending

Could not be determined

30. Name and address of person who completed cause of death (Item 23a)

28a. Date of Injury (Month, Day, Year

Assistant Medical Examiner

32. Registrer's Signature

11. Marital Status 1 Never Married 2 X Marrie	12. Was Decedent Ever in Armed Forces?		13. Was Decedent of H If Yes, specify Cuba		gin? (Specify Yes or N , Puerto Rican, etc.)	lo-	14. Race - Americ White, etc.	can Indian, Black, African
3 Widowed 4 Divorce	ed If Yes, Give Year		1 Yes 2 X	o specify:			Specify: Ame	erican
15. Decedent's Education (Specify			Decedent's Usual Occupa during most of working life			16b.	Kind of Business/Ir	ndustry
Elementary/Secondary (0-12)	College (1-4 or 5+)							nment
12 years 17. Father's Name (First, Middle, Las	et)	IFac	cilities & F	QUIDII	nent Specia rs Name (First, Middle	Maide	t Sumame)	
Emmett W. Jacks	,				iby D. Bund		r Surrame)	
19a. Informant's Name/Relationship (, , ,		b. Mailing Address (Stre					
Natalie Jackson	- Wife	1 5	5210 Carswel	1 Ave	e. #104 Sui	.tla	nd, MD 20)746
20a. Method of Disposition 1 Burial 2 **Cremation 3	Removal from State	cremat	of Disposition (Name of co ory or other place)	emetery,	Date	20c	Location - City or	
4 Donation 5 Other Specif	jy:	ee's	Crematory		7/15/08			nton, MD
1. Signatur - Funer I Serve Lice	risee	1	22. Name and Addres	ss of Facilit	y Stewart I	une	ral Home,	Inc.
23a. Rart I. Enter the disease, or com	pplications that caused the dea	th. Do no	ot enter the mode of dying	n such as c	Road NE Wa	ISN1 rrest, st	ngton, Du	Approximate Interva
failure. List only one cause on e	each line.							Between Onset and
Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence		rdiovascula	r Dis	ease			Deau
if any, leading to immediate	Due to (or as a consequence				•			
	d							
XUNPENDED	AMENDED 23a,pt	II,2	7 per me g8	81 7-	21-08 vt			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	9 Unknown	death	Fetal death 3 Other (Specify)		c pregnancy	2	3d. Date of delivery Month D) Day Year
Part II. Other significant conditions	contributing to death but no	t resultin	g in the underlying cause	given in Pa	art I. 23e. Did	tobacc	use contribute to	the cause of death?
Diabetes Mell	itus, Chronic	Alc	oholism		1Y	es 2	No 3 Prob	oably 4 🗸 Unknown
						opsy form <u>ed</u> ?	prior to c death?	topsy findings available completion of cause of ss 2 No
25. Was case referred to medical examiner?			26.Plac		(Check only one)			
1 Yes 2 No	Hospital: 1 Inpatient 2	ER/O	utpatient 3 DOA	Other ₄	Nursing Home 5	Resid	lence 6 🗸 Other	: Scene

State Registrar 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

1 Yes 2 No

OCME

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

July 4, 2008

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F rtificate of		ental Hyوا ا	giene Reg. No. 20	08	23241
			1. Decedent's Name (First, Middle, La.	st)				2. Date of Dea	ath		3. Time of Death
н	Physicia /Medic		LOUISE M. JOHNSON	N				07	Day 03 2	Year 1008	12:30 P ^M
-	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death		4c. County	of Death	
1			LARKIN CHASE NUR			BOWIE			PRINCE		
	Funeral		5. Social Security Number 6. S	ex 7.Age □M 25☑F	(In yrs. last birthday 71 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt 12/10/1	h ^{V,} Q ^Y 2 ^{ar})	9. Birthp	place (State or Foreign YLAND
Ļ.	Director		578-52-2319 Usual Residence of Decedent	A	/1 110.			12/10/1	. 750	11111	
	/land		10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
	a-fst	ctor	MD PRINCE (GEORGES	FORT WASH	INGTON					1 XYes 2 □ No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	23a ust b	ra	9312 CROSSBOW ROAL	D		20744		L.	JSA		
	tems	aun	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,	can Indian, etc.
36	s afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2√ N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 ☐ No	Specify:		Specify	BLA	CK
0	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show fre Model Examit or must be notified at	Completed by Funeral Director	15. Decedent's Ed		16a. Dec	edent's Usual Occup	pation	1	16b. Kind of Bu	usiness/In	dustry
215	Jin 72	ple	(Specify only highest gra		life.	DO NOT use retire	,	ing			
21;	e filed within al Hygiene. I other than ' vent, it o IN	Som	Elementary/Secondary (0-12)		BUDGE	T ANALYS	[GOVERNM	ENT	
nd	be filed Ital Hygi Ital other event, II	Be (17. Father's Name (First, Middle, Last))			18. Mother's Name	e (First, Middle,	Maiden Surnan	ne)	
<u>yla</u>	2 should be and Mental is marked c raumatic ev	၉	WILLIAM SAVOY				MAUDE SAV				
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. sitem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Modical Examin ar must be notified at		19a. Informant's Name/Relationship (**			and Number or Rur				′
o,	s 1 and 2 soft Health a item 27 is		JOHN JOHNSON/HUS 20a. Method of Disposition	ВАИЛ			V ROAD FT	Date	20c. Location -		
altimore,	permit. Pages Department of Important: If ite any Injury or o		1 Burial 2 □ Cremation 3 □			osition (Name of ematory or other pla	107/14	4/2008	CHELTEN	-	
Ħ	nit. Partme ortan Injur e.	li	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer	-	MD VETERA		ERY in the second secon	R TENKT	NS FIINE	RAT. 1	HOME
B	Depa Impo any Ir		Myan Froc	leuch			OVER ROAD				
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not er	iter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
<	Physician		Immediate Cause (Final disease or condition	BREAST							Onset and Death
	/Medical		resulting in death)	Due to (or as a	a consequence of):						
ı	Examiner	١.	Sequentially list conditions,	b							
	ted sit	nine	Sequentially list conditions, if any, leading to immediate the fundament of Cause (Disease or injury that initiated events	Due to (or as a	a consequence of):						
_6	execu and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequence of):				•••		
8760,	icate be executed physician and the burial-transit	dical		. d							
9		fedi									
Вох	leath certifik attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		☐ Ectopic pregnand	DV			te of deliv	
О. Ш	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown		Other (specify)			I	onth	Day Year
σ.	that the de ned by the a detached f	Phy	Part II. Other significant conditions of	contributing to death bu	it not resulting in the	ınderlying cause giv	ven in Part I	23e. Did to	obacco use cont	ribute to t	he cause of death?
ds,	signe signe	t by	Tarkin outer biginiount conditions of	oning to dough bu	it that resulting the tries	and onlying dudoo give	To the tare to				pably 4 ☐ Unknown
Sor	w requires t s been signe should be o	Completed						24a. Was	an 24h	Wara auto	psy findings available
Re	he lav e has ge 2 ;	п						autop	rmed?	prior to co d <u>ea</u> th?	mpletion of cause of
ta			25. Was case referred to medical				26. Place of Deat	1 □ Yes		1 □ Yes	2X No
<u> </u>	S S I	o Be	examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1 ☐ Inpatie	nt 2 🗆 ER/Outpatie	ent 3 DOA Oth	or:		dence 6 □Oth	ier (Specia	fy)
0	ding Phy After thi funeral o	T:uc	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time (of 28c. Inju	ry at		now injury occur		
Sio.	Attending r death. ector: Afte by the fune	atic	2 Accident investigation	1		M 1 □	Yes 2□No				
Division of Vital Records,	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, si . (Specify)	reet, factory, office		28f. Location (S City or Tou	Street and Numb vn, State)	er or Rur	al Route Number,
	pital ours a sral Derai		29a. Certifier 1 ☐ Certifying Ph	nysician: To the best of	of my knowledge, dea	th occurred at the f	ime date and place	and due to the	causa(s) and m	annor oc	stated
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		niner: On the basis of and manner sta	examination and/or i						
	To the within Fo the somple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
			· ugu	n 1	n)	D0045	5217		07/07/2	800	
2	(10)			completed cause of de	eath (Item 23a) (Type	, Print)					
L					BELT ROAD	COLLEGE I	PARK, MD 2	20740			
	Sta Registr	_	31. Date filed (Month, Day, Year) JUL 0 7 2008	32. Registra	r's Signature	•					
	negistr	aı	JOE 0 1 5004	WORKET SO	1						

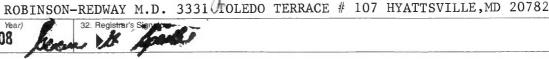
Division of Vital Records, P.O. To the Hospital within 24 hours a To the Funeral I

State Registrar

31. Date filed (Month, Day, Year) JUL 0 7 2008

SANDRA

una



30. Name and address of person who completed cause of death (Item 23a) (Type, Pri

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** July 4, Lemonia H. Kolokythas 2008 5:35 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 ☐ M 2 🕱 F Yrs. 219-68-5851 Director 75 March 17, 1933 Greece Usuel Residence of Decedent death with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28e-f show traumatic event, the Medical Exeminer must be notified at 1 ☐ Yes 24 ☐ No Director Maryland Montgomery Wheaton 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23a 11104 Inwood Avenue 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after i Hygiene. ither than "neturel", or Itel 1 ☐ Yes 2 😿 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: Specify: White þ 3 € Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Pages 1 and 2 should be filed vinent of Health and Mental Hygiesut: If item 27 Is marked other t Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pahagiotis Kotrochios Giagia Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other tra Dimitrios H. Kolokythas/Son 11005 Inwood Avenue, Wheaton, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 8, 2008 Gate of Heaven Cemetery Silver Spring, Maryland 21. Signat/re # Funeral Service Licens 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W,. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications, or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Me Immediate Cause (Final Pnysician Clostidium Difficile Colitis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Septic Shock Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit requires that the death certificate be executed Toxic Megacolon resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Acute Renal Failure the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Deep Vein Thrombosis page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No Division of Vital 1 Yes 2**7 X**No To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2€ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1x Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide 🏗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD 65183 07/04/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue, Takoma Park, MD 20912 Haiying Liang, MD 31. Date filed (Month, Day, Year) 32. Reistrar's Signature 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Leon Gilbert Kinsev 2008 Ju1v4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Washington County 655 Security Rd. Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 17 Birthplace (State or Foreign Country) Min. 1 □ M 2 🗓 F Months Days Hours Nov. 1931 Maryland 217-28-6959 76 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Maryland Washington County Hagerstown 1 ☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 655 Security Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Carmen 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lloyd Mowen Carrie Kinsev Mowen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marian Kinsev 655 Security Rd. Hagerstown. MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 7-5-2008 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD Rose Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home Standarde 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Physician /Medical Examiner sician and burial-transit 299 P.O. Box 68760, attending physician for use as the buria , pal signed by the a t be detached for Division of Vital Records, cate has been si page 2 should b certificate director, After this Hospital or Attending

Exami funeral npletely filled in by the

Physician

/Medical

Examiner

Funeral

Director

28a-f show

death v

Pages 1 and 2 should be filed within 72 hours after and the and Mental Hygiene.

n and Mental Hygiene.

Department of Health a Important: If item 27 is any Injury or other trau once.

altimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "redical Experience and

Physician/Medical ≥ Completed Be

Certification: To

Medical

Natural Natural

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

29b. Signa

(Che one)

To the I within 2 SH 5+1

death.

24 hours after death Funeral Director:

State

ck only	2∐ Medical Exa	miner: On the basis of e and manner state
iture and	title of certifier	1

5 Pending investigation

6 ☐ Could not be

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yea 0 31. Date filed (Month 2008

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Amend item 26, perME G883 9/4/08 TT State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** John Lilja July 3, 2008 10:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett 486 Hazelhurst Lane Swanton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 12/1/1967 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 40 Minnesota 470-82-3511 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 28a-f show 1 ☐ Yes 2 X No ral", or items 23a or 28a-f sh Examiner must be notified Director MD Frederick Knoxville 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 3671 A Petersville Road 21758 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify δ White 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cable Installer ALL Sysyems 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dickson Lilja Jο Ann ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8544 Sycamore Lane N, Maple Grove, MN Amy Griffith/ Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Professional Crem. Ser. 7/10/08 St. Cloud, MN 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Von see 22. Name and Address of Facility 32 S. Second St. 031 21550 Oakland, Maryland Stewart Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sudden Contact gunshot wound to chest /Medical Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXCURNER **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a nonsequence of): Examiner burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav ło in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed it page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Anestdence 6 Nother (Specify) At scene 1 X Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No Subject shot self in chest 7/3/2008 10:00A M 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3XXSuicide 28f. Location (Street and Number or Rural Royte Number, City or Town, State) 486 Hazelhurst Ln. Swanton, MD 21561 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide At home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7/5/08 H26154 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 69 Wolf Acres Road, Oakland, Maryland Dr. P. Daniel Miller, DO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 23246 1- State Amend #2,19b, 7-15-08, per FHDR at Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20<u>0</u>8 **Physician** Month U.1 Carol Ann Lubinsky -200 /Medical Examiner 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Itimore mes toc None Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 PA 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, 1□ M 2√ F Days Hours Min Months 167-40-9194 59 Yrs. 3-26-1949 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits onant: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho. Injury or other traumatic event, the Medical Exercitors must be restified at Director 1 ☐ Yes 2X No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8615 Joseph Ellicott Court 21043 United States Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: white <u>6</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien. Important: If from 27 is marked other the any injury or other traumants. Benefits Administrator Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Edward Joseph Leech Fern Taganowski 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4/29
Roundhill Road Filianth City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anna M. Hardy/Sister Roundhill Road Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Ardent Crematory 7-5-2008 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD rature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 0 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HUDOKIC far esperatory Days disease or condition resulting in death) /Medical as a consequence of): Examiner Weens reumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) schemic sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) the detached 9 Unknown ģ signed I significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 **N**O 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manne f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Catural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director:

Ö Records, Vital

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: Division of

completely To the EG State

Medical

31. Date filed (Month, Day, Year) JUL 07

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of cer-

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

usbeth N lover

Deel

6 ☐ Could not be determined

Registrar

			For State Registrar	State of Ma	aryland		rtment of H		Mental Hy	giene Reg. No2	008	23247
S. S.	Physici /Medic		Decedent's Name (First, Middle,	Last) Mabel Imc	ogene I	eake			2. Date of De Month 07		Ŏ8	3. Time of Death 0603 A M
	Examin		, ,	a. Facility Name (If not institution, give street and number) WMHS-BRADDOCK CAMPUS					h	4c. County ALL		
	Funeral Director	42			e (In yrs. I	a <i>st birthd</i> ay) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th	9. Birth	place (State or Foreign Maryland
	and www.		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Maryl I-f sho fied a	tor	MD	Allegany				Frostburg				1 Yes 2 □ No
	or 28a	Director	10e. Street and Number	meguny			10f. Zip Code			10g. Citizer	n of What Cou	•
	ath wi		100 Honey	suckle Lane Apt				21532		44	US	
36	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notitied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ★ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba I □ Yes 2XNo	Ispanic Origin? (San, Mexican, Puer Specify:	pecify Yes of No to Rican, etc.)		. Race - Ameri Black, White pecify:	
9	2 hou latura ical E	ted	15. Decedent's	s Education		16a. Deced	lent's Usual Occup	ation	rking	16b. Kind	of Business/Ir	
21	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	kind of work done o		KING		и	ome
7	iled w Hygier ther th	Š	12 17. Father's Name (<i>First, Middle, L</i>	ast)			H	lomemaker 18. Mother's Nai	ne (First Middle	Maiden Su		onic
and	d be f ental h ked of	To Be	17. Father & Hallie (First, Middle, 2	James Brow	n			10. 11001010101101		lorence		
Maryland 21215-0036	shoul and M s marl	F	19a. Informant's Name/Relationshi	ip (Type. Print)		19b. Mailin	g Address (Street					
Σ,	and 2 ealth a n 27 l			lady - Niece				mstrong Str				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Pages 1 ment of H ant: If iter jury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		20b. Pi	emetery, crer	sition (Name of natory or other place erland Cremat	1	Date July 07, 2008	C		d, Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service L	Wilholm		1		East Main S	Street Lona	coning,		
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	only one cause on each lir	ie.			ng, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	LAC	J1 C	ACI	00515				eu	104-2-3 day
	Examiner			Due to (or as	a consequ	ence of):	OUSIS TLUAGE					
		ner	Sequentially list conditions, if any, leading to firm solutions cause. Enter Underlying	b. Due to (or as	a consequ	ence of	10011-12					
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		ones of).						
58760,	be exician aburial	al E	,	Due to (or as	a consequ	lence oi).						
687	ificate g phys as the	edical		d								
P.O. Box	The law requires that the death certifics ate has been signed by the attending plagge 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 Fetal	death 3	Ectopic pregnancy Other (specify)	/		230	d. Date of deli- Month	very Day Year
	uires that the de signed by the a Id be detached f		9 ☐ Unknowrf Part II. Other significant condition	ns contributing to death b	ut not resu	Itina in the u	nderlving cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Records,	uires l signe	d by	Corona		de	leege	, 0 0		1 🗆	Yes 2□I	No 3□Pro	bably 4 Dhknown
00	w requires been sites should be	lete		7					24a. Was			topsy findings available
2	The Is te has	Completed							auto perfe 1∐ Yes	psy ormed? 2. No	prior to c death? 1 ∐ Yes	ompletion of cause of 2 ☐ No
Vita	'slcian: The law s certificate has t lirector, page 2 s	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only			
2	Physical this call dire	ဥ	Yes 2□ No	Hospital: 1 Impatie		ER/Outpatien		4 Nursing I	Home 5 ☐ Res			ify)
on o	ding F After funer	ion:	1 № Natural 5 Pending	(Month, Da		Injury	Wor		28d. Describe	now injury o	occurred	
Division or	e Hospital or Attending Physician: The 24 hours efter death. Funeral Director. After this certificate his etely filled in by the funeral director, page	Certification:	Z	ot be 200 Place of init	ury - At ho c. (Specify	me, farm, str	eet, factory, office	ory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)			ral Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	edical C		g Physician: To the best examiner: On the basis of and manner sta	f examina							
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. Licens			29d. Date s	signed (Month	, Day, Year)
		4	HFed				126			July	6,20	082
			30. Name and address of person w	who completed cause of d	eath (Item	23a) (Type,	Print) Ish Road	۲۱	الماليا	1 h	1	1000
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	p Wal	ish noad	Lumbe	riand i	raryl	and 3	21502
	Registi		.00.00 - 8	3 2008	ces p	A. A.	and o					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Year Lvdia Lopez July 1, 2008 4:50 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2331 Holly Springs Drive Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 DKF Director 578-60-2181 93 20, Oct. 1914 Puerto Rio Usual Residence of Decedent with the Maryland 10b. County show 10a. State 10c City Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shovevent, the Medical Experiency runs be notified at Director 1 □Yes 2 □NO Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2331 Holly Springs Drive 20905 USA death v Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Puerto Rican White ģ 3√√Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Juan Ramos Juanita Bonilla ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lydia Salguero/Daughter 2331 Holly Springs Drive, Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State July 17, Arlington Nat'l 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Frame and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W., Silver Spring, MD 20901 2008 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Coronary Vascular Disease years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last executed and burial-tra Due to (or as a consequence of) Box 68760 attending physician certificate be Physician/Medical the as use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy 5 in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the Ö detached 9 Unknown 9 Unknown ₫. signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 X No 1 ☐Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \$\ Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 😿 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division XX Natural 5 Pending investigation of Funeral Director: A fletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical (Check only one) and manner stated. To the I within 2 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D34032 July 1, 2008 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Jeanne P. Asher, MD 3729 Farragut Ave., Kensington, MD 20895 31. Date filed (Month, Day, Year) Registrar's Signature State 03 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and r **Examiner** 8. Date of Birth (Month, Day, Year 06/25/1947 **Funeral** Days 1□M 2☐XF Hours 578-66-4449 61 WASHINGTON, Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State "natural", or Items 23a or 28a-f show edical Examiner must be notified at PRINCE GEORGES MD FORT WASHINGTON 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 11606 KIMBERLY WOODS LANE 20744 USA filed within 72 hours after death well Hygiene.

New Yor Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X. Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: by 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 2 YEARS the TRAVEL EXPENSE MANAGER PRIVATE marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be finance of the first of the fir DONALD ARDALE TAYLOR HELYN WINSTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and S item 27 other tra MICHAEL LYNN/HUSBAND 11606 KIMBERLY WOODS LANE FT. WASHINGTON, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of h
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/14/2008 | CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic Cardiovascoiar **Physician** Y Raws resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 🗷 No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ Cerebral in Fanction Hypertancon 1 Yes 2 No 3 Probably 4 Unknown Completed Diabetes Mellins Chronic Kidney Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has page Itistory of HSV Eucenhalitis Sacral Decubitus this certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No P To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Division or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide after within 24 hours a

To the Funeral I 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 001852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VORE AND 4203 QUEERSON, 12d Hyatts-ille Mid Zu 78-1

State Registrar DHMH 17 Rev 1/2001 1)5

A

31. Date filed (Month, Day, Year) State JUL 0 8 2008 Registrar

29b. Signaturé and title of certif

Mark Parkhurst MD 3110 Gracefield Road Silver Spring MD 20904 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D24093

29d. Date signed (Month, Day, Year)

July 7, 2008

State Registrar Barbara Supanich, MD

31. Date filed (Month, Day, Year)

JUL 0 3 2008

DHMH 17 Rev 1/2001

32. Registrar's Signature

1500 Forest Glen Road Silver Spring, MD

			For State Registrar	State of Maryla			of Health and of Death	Mental Hy	ygiene Reg. No.	2000	23252
	Physic /Medi	cal	Decedent's Name (First, Middle, La John Lawhor	n Sr.		4. 6. 7		2. Date of D Month	Day	/ Year	3. Time of Death
	Fxamile Fxamil	Director	248-62-7603	and Hospita Sex 7. Age (In)	Yrs. last birthdo 69 Yrs City, Town or	If Under 1 Months I Location	Days Hours Mi	rs. 8. Date of B	Pj irth Øay, Year)	rince G 9. Birth Cour 939	olace (State or Foreign of C 10d. Inside City Limits 1 ↑ Yes 2 No
5-0036 72 hours aff	n 72 i "nat ledica	Completed by Funeral Dire	10e. Street and Number 25 Tuckerman S 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	16a. De	3. Was Decedent Yes, specify 1 Yes 25 cedent's Usual e	20011 It of Hispanic Origin? Cuban, Mexican, Pu No Specify: Decupation		Uni	ted Sta 14. Race - Americ Black, White, Specify: Bla ind of Business/In	ates can Indian, etc.
Saltimore, Maryland 2121	ages 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 Is marked other than or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic events or other events or other eve	To Be Cor	10 17. Father's Name (First, Middle, Last Unk。 19a. Informant's Name/Relationship (Lucy Lawhorn/w 20a. Method of Disposition 1段Burial 2 □Cremation 3 □	Type. Print) 7 ife 20 3 Removal from State	25 Was b. Place of Dis cemetery, o	Tucker shington (Name crematory or other control or other control or other crematory or other control or other crematory or other control or other crematory or other	18. Mother's N Eller Street and Number or man St., of or per place)	Rural Route Num NW 10011 Date	orn orn ber, City o	Surname) or Town, State, Zip	own, State
Baltin	permit. Pag Department Important: any injury o		4 Donation 5 Other (Special 21. Signature of Funeral Service Lice		esurre	22. Name and	Cem. 7/ Address of Facility H Silver Hi	lodges	& Ed		Md. '.H. Md.20746
8760,	Physician /Medical Examiner fransit phisician and phisician and the purial-transit phisician series of the principle of the p	dical Examiner	23a. Part Enter the disease, or comshort, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a constitution of the done caus.) Due to (or as a constitution of the done caus.) Due to (or as a constitution of the done caus.)	uence of):	enter the mode had In A	of dying, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
O. Box 6	eath certificate attending phy for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pre 1	etal death	3 □Ectopic preg 5 □ Other (spec				23d. Date of delive	ery Day Year
rds, P	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but not	resulting in the	e underlying cau	se given in Part I.			use contribute to t	he cause of death?
Il Records,	The law rec ate has beer page 2 shou	Completed						per	is an opsy formed? 2 No	prior to co death?	opsy findings available ompletion of cause of 2⊠No

,	Due to (or as a consequence
) c.	
ľ	Due to (or as a consequence
Ld.	

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

,	
ath	3 ☐ Ectopic pregnancy
1	5 Other (specify)

4□Pregnant 9□Unknown	at time	of	death	

c pregnancy (specify)	
77	

23d.	Date of	delivery	
	Month	Da	ay

Part II.	Other significant conditions	contributing to death	but not resulting in t	ne underlying cause	given in Part

1 🔲 Inpatient

23e. Did tobac	co use con	tribute to the cau	se of death?
1 🗆 Yes	2 No	3 Probably	4 ☐ Unknowi
24a. Was an	24b.	Were autopsy fir	ndings available

		1 🗆 163
		24a. Was an autopsy performed
25. Was case referred to medical	26. Place of Death (C	theck only one)

27. Manuar of Death	
Natural Natural	5 Pending
2 Accident	investigation
3 Suicide	6 ☐ Could not be
4 D Homicida	determined

examiner?

29a

1 Yes 2 No

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1326 Southern avenue

	/			Other:			
2 🗾	ER/Outpatient	3 🔲 🛭	DOA	4	I ☐ Nursing H	ome 5 Residence	6 ☐Other (Specify)
ar)	28b. Time of Injury	М	28c.	Injury at Work?	2 🗆 No	28d. Describe how inju	ury occurred
At home, farm, street, factory, office Specify)				fice		28f. Location (Street a City or Town, Sta	nd Number or Rural Route Number, te)

. Certifier	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the circumstance.

	() A
29b. Signature	and title of cortifie
	11/2

Richard Palmer

29c. License number 0055120 29d. Date signed (Month, Day, Year)

mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 310 Washington

State Registrar

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

To the Hospital or Attending Physician: The law requires that the death certificate be exe

Medical Certification: To Be Completed by Physician/Medical

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23253 State of Maryland / Department of Health and Mental Hygiene 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jul 13, 2008 9:23 am Richard Patrick Leo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany 182 N. Centre Street 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2□ F Yrs. MD Feb 21, 1930 Director 214-30-9925 78 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits f show 10b. County r 28a-f shov notified at 1,□Yes 2□No Cumberland MD Director Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be USA 21502 182 N. Centre Street Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio Specify: þ 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1:2 Lounge and Liquor owner/operator permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Elizabeth Reid Francis Patrick Leo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 daughter 18 N. Allegany Street Cumberland Mary Leo Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/14/2008 Scarpelli Funeral Home, P.A. MD 5 Other (Specify) Cresaptown 4 ☐ Donation 21. Signature Fun rài S 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Dause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death LEUTE MYOCARDIAL INFAREN OR **Physician** DA /Medical Due to (or as a consequence of): Examiner ATTHITIOSCUENOTIC CAMPIOVASCULAR DISITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last? Due to (or as a consequence of): Examine requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1∐ Yes 2 PINO or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 200 N 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred After 1 Certification: Division 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

State Registrar

29b. Signature and title of certifier

DSE

2008

Year)

18

JUL

30. Name and address of

31. Date filed (Month Day)

DHMH 17 Rev 1/2001

within 2

2

HYSICIAN

son who completed cause of death (Item 23a) (Type, Print)

DVERYS

32 Registrar's Signature

29c. License number

MD 912 SITONALIVE CUMBARLAND, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23254 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 June 9:25 AM L. Mangum Dorothy 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 4-5-1928 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 1 □ M 2 1 F Months Days Hours Min Takoma Park, MD 216-22-0956 80 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20902 1131 University Blvd. West Apt# 2120 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🛣No Specify. Specify: White 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Glenwood Burris Virgie Estelle Turner 19a. Informant's Name/Relationship (Type. Print) 19b Mailing Address (Street and Number or Rural Route Number, Gity or Town, State, Zip Code) 1131~ University Blvd. West Apt # 2120~Barbara Ellen Hoskin (Daughter) Silver Spring, MD 20902 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Crematory 7-1-2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Los see 22. Name and Address of Facility Fort Lincoln Funeral Home Brentwood, MD 20722 3401 Bladensburg Road uhay 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIOPUL disease or condition resulting in death) Due to (or as a consequence of): SPIRATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): HYPOTENSIVE that initiated events resulting in death) Last Due to (or as a consequence of) IE FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed?

Physician /Medical Examiner requires that the death certificate be executed physician Ö Division of Vital Records,

use as the burial-tran been signed by the should be detached certificate has page 2: After thi funeral death. the To the Hospital or Attend within 24 hours after death To the Funeral Director:

Physician/Medical Examiner

Completed by

Medical Certification; To Be

filled in by

completely

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

မ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Exercited required at

Saltimore, Maryland 21215-0036

		1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No											
25. Was case referred to medical	26. Place of Death (26. Place of Death (Check only one)											
examiner? 1 ☐ Yes 2 ☐ No	pital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)												
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	n (Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	3d. Describe how injury occurred											
3 Suicide 6 Could not to determined		3f. Location (Street and Number or Rural Route Number, City or Town, State)											

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

06, 29, 2008

M) 265069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sirak Lemma, MD

1500 Forest Glenn Rd Silver Spring, MD 31. Date filed (Month, Day, Year)

State Registrar

JUL 0 3 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05040 State of Maryland / Department of Health and Mental Hygiene Paul Cecile Munson Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day June 30, 2008 0835 hrs PAUL CECILE MUNSON **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Fort Washington 9900 Indian Head Highway 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Davs Hours Director Country) 08/21/1964 DC 1X M 2 F 43 Yrs 578-98-9758 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No MD PRINCE GEORGES FORT WASHINGTON 28a-f shov other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 1489 POTOMAC HEIGHTS DRIVE 20744 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Armed Forces 2 X No permit. Pages I and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygene. Important: If item 27 is marked injury or other re-Yes Specify: BLACK Yes 2 X No specify: Give Yee Widowed Divorced ρ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) HANDYMAN MAINTENANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THOMAS LEE MUNSON MARIE BROWN MUNSON Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3805 WINDBROOK PLACE, CLINTON. MICHAEL MUNSON/BROTHER MARYLAND 20735 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 WALDORF, MD HERTTAGE MEMORTAL CEMETERY 07/05/2008 Donation 5 Other Specify: THORNTON FUNERAL HOME, PA ROAD, INDIAN HEAD, MD 20640 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Thin 3439 LIVINGSTON ROAD, INDIAN HEAD, de Co M00557 Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician failure. List only one cause on Mindical a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 ✔ No 3 Probably 4 Unknown ð Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✔ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical å Other₄ Hospital: examiner? Residence 6 V Other: Scene Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 1 🗸 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Jun 30, 2008 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Pedestrian struck by auto 0825 hrs 1 Natural 1 Yes 2 ✔ No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) 9900 Indian Head Highway, Fort Washington, MD Suicide determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of certifier July 1, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner gistrar's Signature 31. Date filed (Month State 2008 Registrar

OCME

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Certificate of	Death	Reg. N	ZUU8	23256
	Physicia	an	1. Decedent's Name (First, Middle, La	•				2. Date of Death	3, 27 8 5	3. Time of Death
	/Medic		Mary Rose MILE							
*	Examin		4a. Facility Name (If not institution, gir Saint Joseph	Medical C			r Location of Death	n		imore
	Funeral Director		219-52-1220	Sex 7. Age 1	(In yrs. last birti	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Feb. 11,	1933 9. Bir Co	thplace (State or Foreign ountry) [aryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
	Mary -f sho	to	Maryland Washi	ngton		Hagers	town			1 ∐Yes 2 ⊠ No
	n the	irec	10e. Street and Number	8 • • • •		10f. Zip Code		10g. (Citizen of What Co	buntry?
	th with	Funeral Director	16732 Broadford	ing Road			21740		USA	
	r dea	nue	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	be filed within 72 hours after death with the Maryland rial Hygiene. 3d other than "natural", or items 23a or 28a-f show event, it e Mexical Examinar must be a calified at	þ	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 XNo If Yes, Give Year or Dates:)	1 ∐Yes 2 ∑XNo	Specify:		Specify:	white
2	72 ho	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	oation during most of work	ing 16b.	Kind of Business	/Industry
7	within sne. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	homemake			ner own 1	nomo
N O	filed v Hygid Sther ent, II	ပိ	17. Father's Name (First, Middle, Las.	0		Homemake		e (First, Middle, Maid		none
yland	ild be fental rked c	To Be	William Keefer				Nellie E	Shelman		
Магу	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If tiem 27 Is marked other it any Injury or other traumatic event, It: once.	_	19a. Informant's Name/Relationship Raymond Miley -			Mailing Address (Street				
ā,	s 1 an if Hea item ?		20a. Method of Disposition		20b. Place of	Disposition (Name of y, crematory or other place	1	Date 20c.	Location - City or	Town, State
Ē	Page nent o int: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			Hill Cemete		/08 Ha	gerstown	, Maryland
Baltimor	apartn spartn sports sy Inju		21. Signature of Funeral Service Lice			22. Name and Addre	ess of Facility	MINNICH F	UNERAL H	OME
D	20 E 8 9		Fred LUS			415 E. Wil			own, Md.	1
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused to one cause on each line	he death. Do n	ot enter the mode of dyi	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
•	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		DIAL INFAF	RCTION			
	Examiner			Due to (or as a		n: ERY DISEAS	3E			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a						
	scuteo .nd transit	Examiner		c						
Ď,	be exe ician a burial-l	al Ex	resulting in death) Last	Due to (or as a	consequence o	f):				
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DOX (To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at t	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of de Month	elivery Day Year
7	d by tletach	Phy	9 Unknowh				and Detail	00a Did tabasa	o una sontributa t	a the source of death?
ď,	ires the signeral pe d		Part II. Other significant conditions SEVERE CHRONIC	_	•	, , ,		1 Yes		o the cause of death? Probably 4 ☐ Unknown
Hecords,	requ been should	eted	SEVERE CHRONIC	OBSTRUC	TIAR	ODMONANT	DIOBNOL			
HG =	The lav	Completed by						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of s
VITAI	ician: certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:		04		th (Check only one)		
0	Phys rthis ral dir	٦.	1 Yes 2 No 27. Manner of Death	1 Inpatien 28a. Date of Injury		patient 3 DOA		ome 5 Residence		ecify)
0	nding ath. r: Afte ie fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day,	Year) Ir	ijury Woi	rk?]Yes 2 □No	28d. Describe flow ii	ijury occurred	
DIVISION	al or Atter after der I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, far (Specify)	m, street, factory, office		28f. Location (Street City or Town, St	and Number or Frate)	iural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, r	Medical C	29a. Certifier (Check only one) 1 Certifying P	hysician: To the best of miner: On the basis of and manner state	examination and	, death occurred at the t d/or investigation, in my	ime, date and place opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner a and place, and du	as stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1		29c. Licens		29d.	Date signed (Mon	th, Day, Year)
7			30. Name and address of person who	completed cause of dea	ath (Item 23a) (-		, (
クト	-7		BOON POH LIM.	M.D. 760		ER DRIVE	TOWSON.	MARYLANI	21224	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 7	32. Registrar	's Signature	Sarle				
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			For State Registrar		Marylan	d / Depa		t of H	lealth a		ental Hy	giene	2008	3 23257
			Decedent's Name (First, Middle	e, Last)					Journ	2	2. Date of Dea	ath		3. Time of Death
	Physici /Medio		EDOMO			MA	1226			5	Month	Day 4	2008	
	Examir		4a. Facility Name (If not institution		er)				Location o	of Death		4c. Co	ounty of Death	1
	Funeral		The Johns Hopkins 5. Social Security Number	6. Sex 7	. Age (In yrs. I	ast birthday)	Baltin If Under	1 Year	If Under		3. Date of Birt	h Voor)	9. Birth	nplace (State or Foreign
ı	Director		171-24-7894	1 X X M 2□F	78	Yrs.	Months	Days	Hours	Min.	(Month, Day		Penr	nsylvania
	land ow t		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Mary ta-f sh ffied a	ctor	Maryland Was	hington		Sh	arpsbu	ura					ĺ	1 ☐ Yes 2X No
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show nt, the Medical Examiner must be notified at	Director	10e. Street and Number	_			10f. Zip-					10g. Citizer	of What Cou	intry?
	ns 236	Funeral	5019 General B	ranch Ct.	ent Ever in U.S	S. 13. 1	Was Decede		1782	ain? (Speci	fv Yes or No-	14.	Race - Ameri	
စ္	or iter		1 Never Married 2 Mar	Armed Ford	es? 2 No 194	48-	lfYes, speci 1 □ Yes 2		n, Mexican Specify:	, Puerto Ri	ify Yes or No- can, etc.)		Black, White	, etc.
21215-0036	hours ural",	d by	3 Widowed 4 Divorced	Year or Date	es: 195	2							of Business/I	nite
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212	d with giene.	Som	Elementary/Secondary (0-12)	4	UI 5+)		Park	Ran	ger				Gover	nment
<u>n</u>	ed fall	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name (First, Middle,	Maiden Su	ırname)	
Maryland	should ind Men s marke umatic (ပု	Bortolo M 19a. Informant's Name/Relations	azzer hip (Type. Print)		19b. Mailir	ng Address	(Street a		sta er or Rural		er, City or To	own, State, Zi	ip Code)
	1 and 2 she Health and tem 27 Is m other traums		A. Christine M	azzer - Wi	fe	5019	Gener	al l	Branc	h C±	Sharn	shurc	Mary	land 21782
Baltimore,	es 1 a of Hea fitem rothe		20a. Method of Disposition 1 Burial 2 Cremation		20b. P	lace of Dispo emetery, crer	sition (Nam natory or ot	ne of ther place	e) :	Dat	te	20c. Local	tion - City or	Town, State
Ē	tment of l tant: If Ite		4 Donation 5 Other (S	ipecify)	Smi	thsbu							burg,	Maryland
Ba	permit. Pages Department of Important: If I any injury or (21. Signature of Fuderal Service	goenspe J							P.A.		msnort	, MD 21795
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that car	used the death								порог г	Approximate Interval Between
E	Physician		Immediate Cause (Final disease or condition		inding	an	rtic	an	eucu	ısm				Onset and Death
u	/Medical Examiner		resulting in death)		as a consto	ence of):				,				
		Jer	Sequentially list conditions, if any, leading to immediate	b Due to (o	r as a consequ	uence of):								
	uted d ransit	Examiner	Cause (Disease or injury that initiated events	с										
oʻ	te be executed ysician and he burial-transit		resulting in death) Last	Due to (o	r as a consequ	uence of):								
Box 68760,	tificate b g physic as the t	Physician/Medical		d										
9 x 6	The law requires that the death certifica tee has been signed by the attending phage 2 should be detached for use as the	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna th 2 - Fetal		Ectopic pr	oonano.	,			230	d. Date of deli	very
<u>.</u>	e death	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nt at time of de		Other (spe						Month	Day Year
P.O.	hat the d by tl detach		Part II. Other significant conditi	ons contributing to dea	ath but not res	ulting in the o	underlying c	cause giv	ven in Part	I.	23e. Did to	obacco use	contribute to	the cause of death?
rds,	uires t signe uld be	d by									1 🗆 🕆	Yes 2□	No 3 □ Pro	obably 4 🔀 Unknown
ဝ၁	aw red s beer 2 shou	plet									24a. Was autop			topsy findings available completion of cause of
Ě	The lay ate has page 2	Completed									perfo	rmed? 2 No	death?	2 🗆 No
Vital Records,	Attending Physician: The death. ector: After this certificate by the funeral director, pa	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:	patient 2 🗆	ER/Outpatier	4 0 7 00	Othe	or.		Check only o		Other (Spec	***
10	g Physer this erral di	n: 70	27. Manner of Death	28a. Date of		28b. Time o		3c. Injury Work	/ at		d. Describe			119)
sior	ending a sath. or: After the fune	catio	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	gation		Injury	М	1 🗆 ነ	Yes 2 🗀 l					
Division	I or Atteno after deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	sined 200. I lace o	f injury - At ho g, etc. (Specify		eet, factory,	office		28	If. Location (Cify or Tow		Number or Ru	ral Route Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page	a C		ng Physician: To the b										
	the Ho	edical	one)	Examiner: On the bas and manne		tion and/or in	-			ath occurre				
	To the within 2 To the comple	Σ	29b. Signature and title of certified	2 2 1	MD	חומ			number	20			signed (Month	, Day, Year) 2008
			30. Name and address of person									JUL	7 4,	2000
_	3H-0		NATALIA	GLEBO	VA		7			600 N	orth Wo	lfe St,	Baltimo	re, MD, 21287
	Sta Registr		31. Date filed (Month, Day, Year)		istrar's Signat		book	a						
	riegisti		JUL 0	0 4000	Jane 18 1	AF A	The state of							

DHMH 17 Rev 1/2001

Box 68760 P.0. Division of Vital Records,

Maryland 21215-0036

Saltimore.

Hospital or Attending Physician: The law requires that the death certificate be executed

State Registrar

neum

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30/Name

and manner stated.

31. Date filed (Month, Day, JUL 08

29a. Certifier (Check only one)

29b. Signator of Ind

July 1, **Physician** Erin J. McTernan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛭 F Months Days Hours Min. Director 119-22-9863 78 2, 1930 New York Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modal Evan in the matth once. Director MD OCean Pines Worcester 10e. Street and Number 10f. Zip Code 9 Magnolia Place 21811 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TXNo Specify à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Judge ပ 19a. Informant's Name/Relationship (Type. Print) Dympna Jessich / sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 7/2/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service bicensee Immediate Cause (Final Aspiration Physician disease or condition resulting in death) /Medical Due to (as a consequence of): Examiner Sequentially list conditions, it and a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical 119-22-9863 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify)

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Mary Ann Fallen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Magnolia Place, Ocean Pines, MD 21811 20c. Location - City or Town, State Frankford, DE 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Parkinson disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cerebrovascular accident 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2008 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) Atlantic General Hospital - 9733 Healthway prive Berlin, MD Szymala

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1 8

4c. County of Death

Worcester

10g, Citizen of What Country?

14 Race - American Indian.

Specify: white

16b. Kind of Business/Industry

Own Home

USA

7:35 A

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

2008

2. Date of Death

BA2 State

DHMH 17 Rev 1/2001

To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral

Records,

Division of Vital

40 Fernan, Erin

Registrar

Completed

Be

Certification: To

Medical

31. Date filed (Month, Day, Year)

0 3 2008

32. Registrar's Signature

completely To the within 2

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and The of certifier

31. Date filed (Month, Day, Year)

JUL 0 3 2008

32. Registrar's Signature

30. Name and address 41 erson why completed a use of death (Item 23a) (Type, Print)

and manner stated.

EDGER V. POTTER JR. MD 11701 LIVINGSTON RD. FT. WASHINGTON, MARYLAND

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D42955

29d. Date signed (Month, Day, Year)

JULY 1, 2008

20744

			For State Registrar	State of M	laryland	l / Depa <i>Cer</i>	rtment of I	Health a Death	and Mei		ieme 0 0	8	23261
1	Physici	an	1. Decedent's Name (First, Middle, Last,						2.	Date of Deatl Month	Day	Year	3. Time of Death
1	/Medic Examin	al	Gwendolyn Y. I 4a. Facility Name (If not institution, give		r)		4b. City, Town,	or Location o	of Death	6 .	30 20 4c. County	08 of Death	18:50 ^{P™}
-	LXGIIIII) - -	Prince Georges	Hospita	1		Che	verl	•		F	G.	
	Funeral Director		377 30 1331	x 7. A] M 2∏xF	nge (In yrs. ia 73	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day, – 18 – 1	Year) 935	Coun	lace (State or Foreign try) jinia
	ow or		Usual Residence of Decedent 10a. State 10b. County	·····	10c. City,	Town or Los	cation					1	0d. Inside City Limits
	e Man	Director	D.C.			Wa	shingt	on					1 □ Yes 2 No
	th with th		10e. Street and Number 1815 24th St.	N.E. #T	3		10f. Zip Code 20	002		10	og. Citizen of V U . S	What Cour	try?
980	72 hours after death with the Maryland natural; or iteme 23e or 28e-f ehow deal Examiner mut be notified at	by Funeral	11. Marital Status 1 ↑ Never Married 2 ↑ Married 3 ↑ Widowed 4 ↑ Divorced	12. Was Deceder Armed Forces 1 Yes 27 If Yes, Give Year or Dates	s?] No		Vas Decedent of Yes, specify Cub			y Yes or No- an, etc.)	Blac	e · Americ ck, White, /: Bla	etc.
Maryland 21215-0036	within ane. then "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		r 5+)	(Give	lent's Usual Occu kind of work done DO NOT use retire Nurse	during mos	t of working		16b. Kind of Bu		dustry
land 2	filled Hygi other	To Be Co	17. Father's Name (First, Middle, Last) Thomas Mason			1				First, Middle, M Rando	Maiden Su ил	ne)	
Mary	and 2 should be lealth and Mental m 27 is marked her traumstic ev		19a. Informant's Name/Relationship (7) Barbara Thornt		ter)		g Address (Stree						
Baltimore,	00-		20a. Method of Disposition		20b. Pla	ace of Dispos metery, cren	sition (Name of natory or other pla arity C	(ce)	Date	9	20c. Location -	City or To	wn, State
Balti	permit. Pag Department Importent: i eny injury o		21. Signature of Funeral Service Licens Francy B.		1	9 (Name and Addr	edy S	y Hun St. N	t Fun	eral H ash,D.	Home	20011
N.	Physician /Medical		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each	line. 10Ca/a	Cinx	er the mode of dy	^					Approximate Interval Between Onset and Death
8760,	death certificate be executed xx e attending physician and mid for use as the burial-transit	licai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	is a conseque	ence of):							
O. Box 6	it the death certific by the attending pl tached for use as t	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal of dea	déath 3□	Ectopic pregnand Other (specify)	;y				ite of delive	ery Day Year
rds, P	quires that n signed b uld be deta	ρ	Part II. Other significant conditions co	ntributing to death	but not resul	iting in the ur	nderlying cause g	ven in Part I			es 2 🗖 No	tribute to t	ne cause of death? pably 4 Munknown
of Vital Record	The law requires that sate hes been signed by page 2 should be detailed.	Completed								24a. Was a autops perform	y ned?	Were auto prior to co death? 1 Yes	psy findings available impletion of cause of
Vita	Physicien: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:			0	hor		Check only on			
on of	iing Phys I. Aiter this funeral di	tion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, L	jury 2	R/Outpatien 28b. Time of Injury	28c. Inju		286		ence 6 Oth		y)
Division	if or Attending after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At hon etc. (Specify)	ne, farm, str	eet, factory, office			Location (St City or Town		ber or Rura	al Route Number,
(2	Hospita 24 hours Funerel stely filled	edical C	2 a Cartifier Check only one) 1 Cartifying Phy 2 Medical Exami	nician: To the best iner: On the basis and manner	of examination	rladge, death on and/or inv	conumed at the trestigation, in my	ime, data ar opinion, dea	id place, and ath occurred	d dua to the c at the time, d	ause(s) and make and place,	a har an t and due t	tated the cause(s)
<i>y</i>	To the within 2 To the comple	Me	29b. Signature and title of certifier	0 1				se number			9d. Date signe		
			Phullip	LUV	Mr.		Do	718	52		NLY	1,2	208
L	(4)		30. Name and address of person who c	ompleted cause of	death (Item: 1203 C	23a) (Type,	Print) NSBUR	y Ro	Hy.	ATT50	TUE	M	20181
	Sta Registi		31. Date filed (Month, Day, Year) JUL 0 3 2008	32. Regis	strar's Signa	bre de			-				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK		For State				ificate of		<u> </u>	Reg.	No.	2008 13. Time	2326
Physician	1	Decedent's Name (First, Luis Felip	Middle, Last)	a Martin	nez					ay Yea 08		9 hrs
dical Examine		a. Facility Name (if not instance) 48899 Bay Fores	stitution, give				hb. City, Town, o	or Location of De	ath	4c. County of St. Mary	's	
Funeral Director	5	. Social Security Number	6. Sex	M 2 F	. Age (In yrs. la:		If Under 1 Ye Months Da		Hrs. 8. Date of Birth		1 Eareign	uatemala
any	_	Usual Residence of Deceding 10a. State 10b. C	lent		10c. City,	Town or Locat	ion					rside City Limits Yes 2 No
<u> </u>	ē		St. Ma	ry	С	aliforn	nia T10f. Zip Code	-	100	. Citizen of W	hat Country?	Yes 2 140
the Mary a or 28a	Öİ	10e. Street and Number 45880 S. S	Spring				206		/ S- ority Vos or No-	Guatem	nala - Armerican Inc	jian, Black,
er death with the Maryland or items 23a or 28a-f show r must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 3 Widowed 4		Armed For 1 Yes If Yes, Give Year	2 X No	lf Y	es, specify Cut	oan, Mexican, Pu	atemala	Whit Specify:	e, etc. Hist	anic
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiette. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she ant: If item 27 is marked other than "natural", or items 20a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	leted by	15. Decedent's Education	on (Specify or	or Dates:	e completed)	during r	nt's Usual Occu nost of working	pation (Give kind life. DO NOT use	of work done e retired)	Landso	usiness/industr	y
100e, MD 21215-0036 ages 1 and 2 should be filed within 72 in of Health and Mental Hygiene. It: If item 27 is marked other than " other traumatic event, the Medical	Be Completed	9th 17. Father's Name (First, Magno Mo				<u> </u>		Julia	lame (First, Middle, M a Martinez	aiden Surnam	e)	
Jore, MD 21215-00: es I and 2 should be filed with of Health and Mental Hygiene If item 27 is marked other ti ther traumatic event, the Met	ToB	19a. Informant's Name/R Emma Cas	elationship (Type, Print)		4588	0 S. Sp	ringstee	r or Rural Route Num en Ct. Cal	itornia	wn, State, Zip (Md •	20619
Baltimore, Normit. Pages 1 and Department of Health Important: If item injury or other trau			on remation 3 Other Specify		Ctota	crematory or d Seneral	Cemete	ry	Date 07/08/08	Guat	emala	
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Physician Medical aminer		23a. Part I. Enter the dis failure List only on Immediate Cause Final or condition resulting in	disease a death)	acn line. . Multiple Inj							В	etween Onset and Death
cuted md transit	Examiner	Sequentially list condition if any, leading to immed cause. Enter Underlyin (Disease or injury that in events resulting in deat	iate g Cause nitiated	o	a consequence							
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	sician/Me	IF FEMALE: 23b. Was decedent pregpast 12 months? 1 Yes 2 No 9		1 Live	, outcome of pre birth gnant at time of	2	Fetal death Other (Specify		pregnancy	Month		Year
ires that the dea signed by the a	by Ph	Part II. Other significa		9 01111		t resulting in th	ne underlying ca	use given in Par		es 2 🗸 No	3 Probabl	cause of death?
cords, law require has been si 2 should b	ompleted								perf	s an 24 opsy ormed? 2 ✓ No	prior to com death?	sy findings available pletion of cause of 2 No
/ital Rec ysician: The his certificate director, page	S e C	OF Man area referred	to medical	Hospital:]	ER/Outpat		Place of Death (Check only one) Nursing Home 5	Residence	6 ✓ Other: S	cene
	-	1 Yes 2	No Pendin	28a. Da	Inpatient 2 te of Injury nth, Day Year) 8, 2008	28b. Time 1930 hrs	of Injury 28	c. Injury at Work	? 28d. Describ Passenge		object colli	
Division tal or Attendirs after death. al Director:	Cortification	2 Accident 3 Suicide 6	Investig	gation 28e. Pl	ace of Injury - A		street, factory, o	ffice building, et	c. 28f. Location or Town 48899 Bay	(Street and N , State) Forest Road,	umber or Rural , Ridge, MD	Route Number, City
DIVIS To the Hospital or 4 within 24 hours after To the Funeral Dire completely filled in Figure 2.				sician: To the biner:On the bas	pest of my know sis of examination	deden death o	occurred at the ti stigation, in my o	me, date and pla opinion, death oc	ace, and due to the ca curred at the time, da	to dire piece; t		
To d withi	Modical	29b. Signature and titl		and manne	er stated.		29c.	License number O.C.M.E.		29d. Date	signed (Month 9, 2008	, Day, Year)
0 (2)		30. Name and addres		ho completed of	cause of death (I	Item 23a) miner 1	11 Penn Stre	eet, Baltimor	e, MD 21201			
160	Sta	Melissa Brass			, Registrar's Sig		,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav George Xenofon Nicolaidis 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1**X** M 2 □ F 215-46-1915 76 Sept. 12. 1931 Greece Usual Residence of Decedent 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 2310 Greenery Lane, #201 20906 USA 12. Was Decedent Ever in U.S. Was Deceuent __ Armed Forces? ¹ □Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married White If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Distribution Manager Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Xenofon Nicolaidis Vasiliki Krassas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diamantina Nicolaidis/Wife 2310 Greenery Lane, #201, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State July 7, N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 21. Signar re of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or e cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 No 2 3No 1 ☐ Yes 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 SOther (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred

certificate be executed
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Physician

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permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun

3altimore, Maryland 21215-0036

Box 68760.

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7 is marked other than "naturai", or items 23a or 28a-f shov traumatic event, the Modical Examiner must be notified at

Examiner burial-tran physician Physician/Medical the use as nding p atter the ģ signed t 2 Completed been Jas page 2 Be Certification: To

To the Hospital or Attending Physician: The law requires the within 24 hours after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be d

25. Was case referred to medical examiner? 1 ∐Yes 2 ∐ANo 27. Manner of Death 28c. Injury at Work? (Month, Day, Year) 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie (Check only one) and manner stated

30. Name and address

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 6001 Muncaster Mill Road, Rockville, MD 20855

29c. License number

d64615

29d. Date signed (Month, Day, Year)

July 2, 2008

State Registrar

Medical

31. Sate filed (Month, Day, Year)

JUL 0 7 2008

title of certifier

Genevieve Wroblewski,



- 1

		Pleas	e Type or Pri							gible.	
		For State Registrar	State of M	aryland / De	epartmo C <i>ertific</i>			Mental Hy	rgiene Reg. No. 2	008	23264
Di di		1. Decedent's Name (First, Middle,	Last)					2. Date of De		Year	3. Time of Death
Physicia /Medic		Louise Mary Newh	ouse					June	30	9008	1755 RM.
Examin		4a. Facility Name (If not institution,	give street and number,)	4b. C	ity, Town, or	Location of Death			nty of Death	
		Washington Count				gersto				_	n County
Funeral		5. Social Security Number 230–54–4832	4 DM ONE	ge (In yrs. last birth	Mont	der 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di	ay, Year)	Cor	nplace (State or Foreign untry)
Director		Usual Residence of Decedent		66 Yr	3.			Dec. 20	0,1941	Dist	rictof Col
land ow		10a. State 10b. County Washi		10c. City, Town of	or Location						10d. Inside City Limits
the Maryland r 28a-f show	Funeral Director	Maryland	County	Hagers							1 ☐ Yes 2 🛣 No
vith th	Ö	10e. Street and Number	D		10f.	Zip Code	0		10g. Citizen o		untry?
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afte o	by Fune	Narital Status Never Married 2 Marrie Never Married 2 Marrie Never Married 2 Divorced	12. Was Decedent Armed Forces d 1 Tyes 2 1 If Yes, Give Year or Dates:	No Lever in U.S.		pecify Cuba	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No Pican, etc.)		lace - Amei lack, White cify: Wh	
2 hou	ted	15. Decedent's	Education	16a. D	ecedent's L	Isual Occupa	ation		16b. Kind of	Business/I	ndustry
hin 7 e. an "n	ed.	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NO	work done o T use retired	during most of wor l)	king			
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2 sho		19a. Informant's Name/Relationship	(Type. Print)		_	,	and Number or Ru				Tip Code)
and lealth m 27 her tu		James M. Black-b	rother				or. Chamb				
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exagnce.		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3	☐ Removal from State	20b. Place of D cemetery,	Disposition (i crematory o	Name of or other place	e) :	Date	20c. Locatio	n - City or 1	Fown, State
Pag tmen tant: jury		4 □ Donation 5 □ Other (Spe	cify)		urg C	remato	ory 7-3-	2008	Smithsl	ourg,	MD
ermit lepar npor ny in		21. Signature of Funeral Service Lie	ensee				ss of Facility Do				
<u> </u>		Kartlin 3	affaron)					_	cown,	MD 21742
		23a. Part 1. Enter the disease, - co shock, or heart failure. List or	on I leations that cause nly one cause on each I	d the death. Do no ine.	t enter the n	node of dyin	g, such as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death
Physician	. 1	Immediate Cause (Final disease or condition	_a. A	WITE RI	EN AZ	FAIL	425				Onset and Death
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requires that the death certificate b been signed by the attending physic hould be detached for use as the b	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal death at time of death	3 Ectop 5 Other	ic pregnancy (specify)	у			Date of deli Month	ivery Day Year
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stclar certii recto	Be	25. Was case referred to medical examiner?	Hospital:			DOA Othe	26. Place of Dea				
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ding h. After fune	ig	1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay, Year) Inji		28c. Injury Work	yat (? Yes 2□No	Zod. Describe	now injury occ	urreu	
deatl ctor: y the	ical	3 ☐ Suicide 6 ☐ Could no	t he	iury - At home farm			162 2 10	28f Location	(Street and Nu	mher or Ru	ıral Route Number,
or A after Direction by	Certification:	4 ☐ Homicide determin	building, el	jury - At home, farm tc. <i>(Specify)</i>	,, 011001, 100	.01), 000		City or To	wn, State)	mber or rio	rai riodio Nambor,
spita ours neral		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge,	death occur	red at the tin	ne, date and place	, and due to the	e cause(s) and	manner as	s stated.
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Medical	(Check only 2 ☐ Medical Exone)	xaminer: On the basis of and manner st	of examination and/	or investiga	tion, in my o	pinion, death occu	rred at the time	, date and place	e, and due	to the cause(s)
Nithin Fo th	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date sig	ned (Monti	h, Day, Year)
		1 threat				Door	52006		7/11:	2008	
		30. Name and address of person wi	no completed cause of	death (Item 23a) (To	ype, Print)					3	
N-8			CO - WINFO	M 251	E. AN	DEN	m ST.	itanea	(TOW A	, ,	un
Sta	te	31. Date filed (Month, Day, Year)	32. Resist	rar's Signature	1			- /- / - 10	. , 0 /-		
Registra	ar	JUL 07	2008	M 251 rar's Signature	A754	D .					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** Nelson Warren Paine July 2, 8:18 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**XX**M 2□ F 77 218-24-6692 2, 1930 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 X No Director Maryland Montgomery Silver Spring 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20902 USA 10416 Huntley Avenue Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after Hygiene. 1xx es 2 □ No If Yes, Give Year or Dates: 1948-52 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) marked other than "natur Imatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Legal Practice 5+ Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Avis L'Hommedieu John Carvel Paine and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10416 Huntley Avenue, Silver Spring, MD 20902 Nancy Ann Rush/Sister Health if 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of I Important: If Its any injury or o once. July 3 2008 1 ☐ Burial 2 ☐ €remation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) f Funeral/Service Licen 22. Name and Address of Facility
Francis J. Collins Funeral Home 500 University Blvd, W., Silver Spring, MD 20901 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** days namonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Undeace or in jury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last physician and the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as 1 IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Recent Caubrovas cular accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably Cerebral hemorrhage and status post 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Carrio formy
25. Was case referred to medical examiner? to thrive, dementia To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 2X ER/Outpatient 3 DOA ဥ Director: After th 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide n 24 hours aft ie Funeral D sletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2.

To the I complet 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 143121 Chowdley, mi) CHOWDHURY, MD; 15216 DINO DRIVE; BURTONSVILLE, MD 20866 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygiene 2

Physician /Medical Examiner

Funeral

Director filed within 72 hours after death with the Maryland r 28a-f show notified at ms 23a or "natural", or items the Medical al Hygiene. permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event,

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

death certificate be executed nding physician and use as the burial-tran ed by the this

Box 68760,

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or Vital Records,

al or Attending F s after death. It Director: After id in by the funera Division To the Hospital o within 24 hours aft To the Funeral Di completely filled in Medical State Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 28, 2008 **Claude** Pratt, Jr. June 11:30 A.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crescent Cities Center **Riverdale** Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1**X** M 2□ F 59 082-42-9044 New York May 22,1949 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Directo College Park Maryland Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3417 Duke Street 20740 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married African 1 ☐ Yes 2X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Howard University Elementary/Secondary (0-12) College (1-4or 5+) Producer/Director Television Station 4 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pratt, Sr. 01ga Patterson Claude ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian William Pratt (Son) 3417 Duke Street; College Park, Maryland 20740 July Date, 2008 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State Geørge/Washington Cemetery Adelphi, P.G.; Maryland Donation 5 Other (Specify) 22. Name and Address of Facility

R. Horton Company Morticians, Inc. Signature of Funeral Service Live 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death adder Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Flart I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? enorthye 1∐ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 4 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) はしている Jumo 7 rey 000 31. Date filed (Month, Day, Year) 32. Registrar's Signature

JUL 0 3 2008

State of Maryland / Department of Health and Mental Hygiene 0 0 8 23267 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 26, 2008 **Physician** 16:40 PM Esther Rebecca Proctor /Medical 4a. Facility Name (If not institution, give street and number)
Fort Washington Hospital 4c. County of Death
Prince George's 4b. City, Town, or Location of Death Examiner Fort Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Sept. Days Year) 945 Mary Tand 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M XXF 62 577-67-2002 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State s 23a or 28e-f show ust be notified at 1 ☐ Yes 2 XNo Oxon Hill Director MD Prince George's 10g. Citizen of What Country? USA 10e. Street and Number Of. Zip Code 20745 834 Neptune Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Items Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 **Black** neturel, or 1 ☐ Yes 2 No δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Healthcare 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any jury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Maryanna Unknown Basil Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 834 Neptune Ave., Oxon Hill, MD 20745 Cynthia Proctor - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-2-08 Waldorf, MD Oakland Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bell & Johnson Funeral Home PA 6503 Old Branch Ave., Temple Hills, MD 20748 Enter the disease, or cont k, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit 2 and Due to (or a a consequence of) attending physician Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2XXVo 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 1 Yes 2 XNo 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Propatient 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA this After this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 46046 6-26-2008 30. Name and address of person who completed cause Dr . Amir Mirza-Alikhani, Livingston Rd., Fort Washington, MD 20744 31. Date filed (Month, Day, Year)
JUL 0 3 2008 32. Registrar's Sign State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** P M Cora Irene Quinn 2008 3:56 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, June 19, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛣 F Yrs 1926 West 82 June 578-28-7651 Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10b County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercises must be notified at 1 ☐ Yes 2 ☐ No Director Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20715 13105 Idlewild Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Sears & Roebuck Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Densmore Charles Earl Penn ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any injury or other traun 3462 South River Terrace 21037 Edgewater, MD Judith A. Leahy / Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/11/2008 Gate of Heaven Cem. Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Beall Funeral Home ewnh Bowie, 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det Division of Vital Records, Completed by 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No certificate 1 ☐ Yes 2 🕻 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Certification: Hospital or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

Re Funeral Director; A

bletely filled in by the fu 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5 30 Name and address of person who completed cause of death wm 23a) (Type, Print) 31. Date filed (Month, Day, Year) State JUL 0 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Dorothy Mary Rasmussen 2008 1:20 A M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Annapolis Anne Arundel 2791 Autumn Chase Run If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 200 158-22-2521 77 Yrs. 10, 1930 New Jersey Dec. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 X No

10f. Zip Code

1 □Yes 2 📆 🖠 o

20b. Place of Disposition (Name of cemetery, crematory or other place)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

21060

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

Own Home

20c. Location - City or Town, State

18. Mother's Name (First, Middle, Maiden Surname)

Louise Grantowski

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

2791 Autumn Chase Run Annapolis, MD

U.S.A.

14. Race - American Indian,

White

Black White, etc.

Funeral Director

10e, Street and Number

7885 Gordon Court

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

1 Never Married 2 Married

3 XWidowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Frederick Hoffman

19a. Informant's Name/Relationship (Type. Print) Amy Jabin/daughter

12

20a. Method of Disposition

12. Was Decedent Ever in U.S. Armed Forces

2 X No

1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:

College (1-4or 5+)

Physician

/Medical

Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment results to nutified at once. Director Funeral \$ Completed Be ٥

Baltimore, Maryland 21215-0036

Box 68760,

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Records,

Division of Vital

Physician /Medical Examiner

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Certification: To

law requires that the death certificate be executed burial-transi and attending physician for use as the buria ned by the a signed t icate has been sig ; page 2 should b certificate has The spital or Attending Physician: Ti hours after death. Ineral Director: After this certificat y filled in by the funeral director, pa

To the Hospital within 24 hours a To the Funeral I Medical State

Registrar

Baltimore Crematory 7/2/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma of lung years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic obstructive pulmonary disease YSYes 2 No 3 Probably 4 Unknown Cirrhosis of liver 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 2XXVo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{XOther (Specify)} \) 1 ∐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🙀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1Xxertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 21684 7/1/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8021 Ritchie Highway C.V. Cyriac, MD Pasadena, MD 21122 Registrar's Signature 31. Date filed (Month, Day, Year)

Ronald Rakowsk		Sta I- For State Registrar	ate of Maryla		artment of rtificate of		and	Menta		ı	Reg. No.	200	, ,	2327
Physicia Medical Exami	an/	Decedent's Name (First, Middle	•						2	Month	Day	Year		ne of Death 00 hrs
viculcal Exami		Ronald J. 4a. Facility Name (if not institution	Rakowsk:		4	b. City, To	wn, or Lo	ocation of	Death	June 26,		. County of Deat		
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under Hours	24Hrs. Min.			(DD/YYYY) 9. B Fore	ign	1
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21215 uld be file Mental Hy marked o	Be	Edward J. Rakov						Step	hani	e J.,	Bada	ch		
O & B is 2	욘	19a. Informant's Name/Relations			- P		,					City or Town, Sta	te, Zip (Code)
Baltimore, MI permit. Pages I and 2 s Department of Health as Important: If item 27 injury or other traum		Maureen M. Rakowsk: 20a. Method of Disposition	i, sister-i		5432 St					tt City Date		21043 Location - City	or Town	State
Baltimore, permit. Pages I an Department of Hes Important: If ite		1 X Burial 2 Cremation			crematory or oth		- -		T 1	2 2006	. إ	Irrom Comis	M	T)
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Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.						rdiac or	respiratory a	irrest, sh	ock, or heart		proximate Interval tween Onset and Death
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Box 6876 e death certificate the attending phy	sician/M	23b. Was decedent pregnant in the past 12 months?		birth nant at time of d	leeth -	tal death her (Spec	3 <u> </u>	Ectopic	pregnar	icy		Month	Day	Year
Box e death the atte	Physic	1 Yes 2 No 9 Un	known g Unkr	nown	J	nei (opec	·y/		200=					
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of ing Ph After t uneral	n: To	27. Manner of Death	28a. Date (Mon	e of Injury h, Day,Year)	28b. Time of I	Injury 2		y at Work		28d. Descrit	e how in	njury occurred		
Sion Attend death. ctor:	atio		ding stigation					es 2		00f I+i-	- (04====	and Number or	Dural D	oute Number, City
Division of Vital Records, tat or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should t	Certification:	dete	Id not be 28e. Pla ermined (Specify		home, farm, stre	et, ractory,	onice bu	maing, etc			n, State)	and Number of	NUI AI N	oute Number, Oity
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To the H within 24 To the Fu	Medical	one) 2 Medical Example 29b. Signature and title of certification	miner: On the basis		ang/or investiga			death occ	Jurred at	are time, da		I. Date signed (I		
12	~	Constitution and the or certific	111	,		200	O.C.N					ne 27, 2008	, &	
		30. Name and address of persor	who completed car		m 23a)						ш			
		David Fowler M.D.	Chief Medical	Examiner	111 Penn S	treet, Ba	altimor	e, MD 2	21201					
S Regis	tate trar	31. Date filed (Month, Day, Year)	2008	Registrar's Sign	ture (b)	1								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month DAVID KENT ROGERS 5 2008 12:38 A^M JUL 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MONTGOMERY NATIONAL NAVAL MEDICAL CENTER **BETHESDA** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days Months Hours 129-26-3712 75 APRIL 6, 1933 NEW YORK Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits VA 1 ☐ Yes 2 🙀 No FAIRFAX ALEXANDRIA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7312 STAFFORD ROAD 22307 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OFFICER U.S. ARMY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN ROGERS IDA BEYER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELLE ROGERS 7312 STAFFORD RD ALEXANDRIA, VIRGINIA 22307 WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 7/9/ 2008 FALLS CHURCH, VA 4 □ Donation 5 □ Other (Specify) NATIONAL CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DEMAINE FUNERAL HOME 520 S. WASHINGTON ST, ALEXANDRIA, VA 22314)Iana 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): CHRONIC LYMPHOCYTIC LEUKEMIA Sequentially list conditions, the state of t Due to (or as a consequence of): IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?

Physician /Medical **Examiner**

Physician

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Examiner I or Attending Physician: The law requires that the death certificate be executed after clearth.

I pirector: After this certificate has been signed by the attending physician and in by the funeral director, and and a fin by the funeral director, page 2 should be detached for use as the burial-transit ian/Medical completely filled

Division or Vital Records, P.O. Box 68760,

1ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of death 5 □ Other (specify 9 □ Unknown	′)		
ed by Pr	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause	given in Part I.		ee contribute to the cause of death? No 3 Probably 4 Unknown
Complet				24a. Was an autopsy performed? 1□ Yes 2 XNo	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
<u>u</u>	25. Was case referred to medical		26. Place of Death (Ch	heck only one)	
0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ∏ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home	5 ☐ Residence 6	☐Other (Specify)
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury M	Injury at Work? 28d. 1 ☐ Yes 2 ☐ No	Describe how injury	occurred
,eLIIIC	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ice 28f.	Location (Street and City or Town, State)	I Number or Rural Route Number,
cal		hysiclan: To the best of my knowledge, death occurred at the miner: On the basis of examination and/or investigation, in a			

State Registrar 29b. Signature and title of certifier

ROBERT F. BROWNING
31. Date filed (Month, Day, Year)
JUL 0 8 2006

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

29c. Lîcense number

D-64164

CENTER

29d. Date signed (Month. Dav. Year)

NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600

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and manner stated

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32. Registrar's Signatur

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			Ctate of Manuard / Department of Llag		-	-	
			1- State of Maryland / Department of Heal Certificate of De			2000	23272
			Registrar 1. Decedent's Name (First, Middle, Last)	alli	2. Date of Deat	g. No.	3. Time of Death
н	Physici		Howard Neil Sweitzer		Month July	Day Year 8 2008	2:55 P. M
)	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Loc	cation of Death		4c. County of Death	
			Dennett Road Manor Nursing Home Oakland			Garrett	
	Funeral		Months Days H	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day,	Year) Cou	place (State or Foreign ntry)
	Director		214-34-1793 1X M 2 F 71 71 Vrs. 1 S M 2 F 71 Vrs. 1 S M 2 F 71 1 S		Oct. 13,	1936 Mar	yland
	/land		10a. State 10b. County 10c. City, Town or Location		-		10d. Inside City Limits
	Man a-f sh	ţō	MD Garrett Oakland				1 ☐ Yes 2 📉 No
	th the or 284	Jirec	10e. Street and Number 10f. Zip Code	**	į.	og. Citizen of What Cou	
	ath wi	Funeral Director	1264 Underwood Road 21550			United Star	
	er de	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ▼ Married 11. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces?	nic Origin? (Spe lexican, Puerto l	Rican, etc.)	14. Race - Ameri Black, White,	
36	irs aft	by F		pecify:		Specify: Wh:	ite
Š	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examir at must be notified at			n na most of workii	na	16b. Kind of Business/Ir	dustry
2	within ene.	Completed	Elementary/Secondary (0·12) College (1-4or 5+)		.5	Insurance	
2	e filed within al Hygiene. I other than ' vent, the Me		12 Insurance Agent 17. Father's Name (First, Middle, Last) 18.		(First Middle A	Maiden Sumame)	
and	d be f antal h red of	o Be		Frieda	Rhodes		
Maryland 21215-0036	2 should be and Mental Is marked of raumatic ever	မ	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and I</i>	Number or Rura	l Route Number,	City or Town, State, Zij	c Code)
ž	alth a alth a 27 ls		Mrs. Rita Sweitzer Wife 1264 Underwood	Road, O	akland,	MD 21550	
ore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	i i		20c. Location - City or T	own, State
Ĕ	Pagment ment ant: h		'4 □Donation 5 □Other (Specify) Garrett Memorial Ga			Oakland, M	D
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee 22. Name and Address of David A. B	Facility Burdock	Funeral	Home, P.A.	
	40200		21 N. Seco			1, MD 21550	Approximate
	Dharisian		shock, or heart failure. List only one cause on each line.				Interval Between Onset and Death
}	Physician /Medical		Due to (or as a consequence of):		MOST PECE	nt 4/29/08	
П	Examiner		Sequentially list conditions. b. Congestive Heart Fa	ilure			Years
	P	iner	if any, leading to immediate Due to (or as a consequence of):				days
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	2			Mays
760,	be execute sician and burial-tran	cal E					
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edic	0.				
Box 68	h cert ending	Z-	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of deliv	
	ne deat the att	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Month	Day Year
P.O.	that the de ed by the detached	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Parti	23e Did toh	acco use contribute to	the cause of death?
	signed be del		Diabetes, HTN, hyperlipidemia, BPH, neuro		1 □ Ye	V	bably 4 □Unknown
Š	w require been si should I	etec	nephropathy, seizure disorder	1	24a. Was ai	7 -	onsy findings available
Rec	The fav	Completed by	TREPATIONALLY SELECTE ALSOVORE		autops	y prior to co	opsy findings available ompletion of cause of
tal	iician: Th certificate rector, pag	Be Co	25. Was case referred to medical 26	. Place of Death	1 ☐ Yes 2		2□ No
~	ysick is cer direct	To B	examiner? 1 Yes 2 No	4 Nursing Hor	ne 5 ☐ Reside	ince 6 Other (Speci	fy)
0	ng Pt fter th ineral			1		w injury occurred	
sio	tendi Jeath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be 289 Place of Injury. At home farm street factory office	2 No	20f Location /Ct	reet and Number or Rur	al Poute Number
Division of Vital Records,	or At after c Direc in by	ertification:	4 ☐ Homicide 3 ☐ Strictor 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide	1	City or Town		ar noble Number,
	spital	O	77				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	on, death occurre			
	To the To the Comp	Σ	add. digital and an analysis of the same and an analysis o			9d. Date signed (Month)	
		11	The contract of the contract o	64709	ر J	uly 9, 2008	3
		4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Porter, DO 311 N. Fourth St.,	Suite 1	. Oaklan	d. MD 21550	0
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	June 1	,		
	Registi		JUL - 9 2008 Same & Species				
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DHMH 17 Rev 1/2001

State Registrar

Dr. Robert Goralski, MD

9 2008

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2040 Month 6/29 /2/008 **Physician** Robert G. Schied /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Annapolis **Examiner** Anne Arundel Medical Center 9. Birthplace (State or Foreign Country) Michigan If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Year 1/17/1940 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 68 **Funeral** Months Days Hours **XIX** M 2□ F 371-38-3169 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Medical Examination and Injury or other traumatic event, It. Medical Examinations and Injury or other traumatic event, It. Medical Examinations. 10c. City, Town or Location 10h County 1 ☐ Yes XX No Director Anne Arundel Annapolis MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21409 7 Arlie Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status White ☐Yes 2 Yes, Give 2 X No 1 Never Married 2KMMarried Specify: 1 ☐ Yes 2X No Specify. Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Sales Marketing Sales Rep 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aline Gamin Edward Schied 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Arlie Dr. Annapolis, MD 21409 19a. Informant's Name/Relationship (Type. Print) Spouse Bernadette Schied 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Annapolis, MD St. Mary's Cemetery 7/9/2008 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Annapolis, MD 21401 23a. Part1. Enter the disease, Complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and use as the burial-trar Due to (or as a consequence of): physician P.O. Box 68760, Physician/Medical attending p for use as 23d. Date of delivery If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant Year 3 Ectopic pregnancy Day in the past 12 months? 5 Other (specify) □Yes 2□No ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed be should be deta Division of Vital Records, 2 No 3 Probably 4 Unknown 3 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy cate has t page 2 s 1 ☐ Yes certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 1 ☐ patient After this c Certification: To 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury 27. Manner of De (Month, Day, Year, Injury 5 Pending investigation s after dea. al Director: After 1 Natural 1 □Yes 2 □No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide filled in by 4 Homicide The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Control basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and transcribed and transcribed and transcribed. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State 2008 02 Registrar

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30. Name an press of person who impleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Jane Schneider 2008 2:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7474 Worcester Hwy. Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/30/1927 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 🗙 F 579-32-7897 80 Washington DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Worcester Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7474 Worcester Hwy. 21811 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. l □Yes 2 X No f Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛛 No \$ Specify. 3 ☐ Widowed 4 【 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Budget Clerk Health Care Department of Health and Mental Hygiv Important: If Item 27 Is marked other: any injury or other traumatic event, tt once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Lartz Sarah Stover 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Schneider / son 3833 Hatcher Place, Rosamond, CA 93560 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 7/2/2008 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Lic 108 William St., Berlin, MD 21811 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) notestatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 20 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury n 24 hours after death.

ne Funeral Director: Af olderely filled in by the fur 1 ☐ Yes 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

To the Fun

completely and manner stated, 286. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 4a-c, 26 per doc 8882 8-22-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** William Shue Albright 2008 July /Medical 4a. Facility Name (If not institution to the street and House 4b. City, Town, or Location of Death

Alexandria Potomac 4c. County of Death

Montgomery Examiner 4024 Ellicott Alexandria If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1**X** M 2□ F 032.01.3303 87 May 18, Massachusetts Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show adval Examiner must be notified at 1 ☐ Yes 2 No Directo Alexandria Virginia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 4024 Ellicott Street 22304 Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW- II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Interstate Commerce n and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 9 Commission Judge traumatic event. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked ofth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harden Albright Shue Anna Blake 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 Garnett Drive Chevy Chase, MD 20815 Robert Blake Shue/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Bunal 2 ☐ Cremation 3

☐Removal from State Sept.22,2008 Arlington, VA Arlington Nat. Cem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Alzheimer's Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and Due to (or as a consequence of) $\mathcal{H}_{\mathcal{Q}_{-}}/\mathcal{L}_{-}/\mathcal{C}_{-}$ or Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed? Yes 2 No Be 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Injury 1 XNatural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D39456 July 1, 2008

Registrar
DHMH 17 Rev 1/2001

State

5530 Wisconsin Avenue; Chevy Chase, MD 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Registrar's Signature

Lila T. McConnell, M.D.

31. Date filed (Month, Day

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 3, **Physician** Bernard V. Somers 2008 4:45 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Convalescent & Rehab Ctr Crofton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 3, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1914 Months Days Hours Min. 1'**X** M 2□ F Minnesota Jan. 469-07-8293 94 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Collier Marco Island FL 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code (205 North) USA 34145 140 Seabew Ct. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M/Yes 2 □ No If Yes, Give Year or Dates: 1943–45 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Iter 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Journal Clerk of the Senate U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Cleary William R. Somers ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20695 9710 Faith Baptist Church Rd. White Plains, MD 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any Injury or other traum once. Martin W. Somers / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 12008 Metropolitan Crem. Alexandria, VA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cecliac **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 🗌 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2□ No 24a. Was an certificate has To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Watural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

UA State

Registrar DHMH 17 Rev 1/2001 29a. Certifier

29b. Signature

nd title of certifier

0.8 2008

Medical

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DS 7028

29d. Date signed (Month, Day, Year)

			For Amend Item 12	te of Mary per inf	land / Dep , g881, 0	artment of l	lealth a	and Mental Hy	giene	
	-	-	Registrar 1. Decedent's Name (First, Middle, Last)			rimouto or	Douin	2. Date of De	ath ZU	3. Zimbof Zeath
	Physicia /Medic	-	Harold Gerstell Sho	wacre				July	5 20	08 8:17 AM
	Examin		4a. Facility Name (If not institution, give street a 21 Carvel Dr.	nd number)		4b. City, Town, o		f Death	4c. County of	ne Arundel
	Funeral Director		5. Social Security Number 6. Sex 1218-09-5355 1質M 2		yrs. last birthday Yrs.	If Under 1 Year Months Days	If Under : Hours	Min. 8. Date of Bir (Month, Da	th Year)	9. Birthplace (State or Foreign Country) Maryland
	w w		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	Maryli f sho ied at	jo	MD Anne Arunde	1 A	nnapolis	!				1 □Yes 2 2No
	r 28a	Director	10e. Street and Number		IIIQPOLIA	10f. Zip Code			10g. Citizen of Wh	nat Country?
	23a c ust be	ralD	21 Carvel Dr.			214	109		USA	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 Married 1 □	s Decedent Ever ned Forces? Yes 2 ☐ No es, Give ar or Dates: 19	45	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Ori an, Mexicar Specify:	gin? (Specify Yes or No n, Puerto Rican, etc.)	14. Race Black, Specify:	- American Indian, White, etc. White
00	2 hour atural cal Ex	ted t	15. Decedent's Education		16a. Dece	edent's Usual Occu	pation		16b. Kind of Busi	
Maryland 21215-0036	t. Pages 1 and 2 should be filed within 72 houn rtment of Heath and Mental Hyglene. rtant: If item 27 is marked other than "natural" jury or other traumatic event, the Medical Ex.	Completed	(Specify only highest grade comp Elementary/Secondary (0-12) Co	llege (1-4or 5+) 5+	life. Teac	e kind of work done DO NOT use retire	during mos d)	t of working	 Educati	on
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)	<u> </u>	reac	TICI	18. Mothe	er's Name (First, Middle		
ılan	uld be Mental irked c	To Be	Edgar Harrison Sh	owacre			Elsi	e Gerstell		
lary	2 sho and h is ma		19a. Informant's Name/Relationship (Type. Pri	nt)	19b. Mail	ing Address (Street		er or Rural Route Numb		tate, Zip Code)
	es 1 and 2 of Health a f item 27 is r other tra		Mary H. Showacre / W 20a. Method of Disposition	ife		Carvel Dr.		nnapolis, i		bity or Town, State
nor	ages ent of t: If it		1 Burial 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	ii irom state i		osition (Name of ematory or other pla		7/10/2008		
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee					Beall Fur		
Ä	permi Depar Impor any Ir		1 /leva /len		0	6512 NW (Crain	Hwy. Bow.	ie, MD 2	0715
	Physician	7	23a. Part1 Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition	s that caused the se on each line.	S	heart -	0 /	,	urrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a) o						
1	₽ #	iner	ceues. Enter Underlying	Due to (or as a co	nsequence of):					
10	xecute and	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
8760,	cate be executed physician and the burial-transit	dical E	d							
9	sertifica ding ph	Med	IF FEMALE:	una autaama nf n	roananav					
.O. Box	requires that the death certific een signed by the attending p hould be detached for use as	Physician/Me	in the past 12 months?	es, outcome pf p Live birth 2 Pregnant at time Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	су		23d. Date Mon	of delivery th Day Year
S, P	res that igned b be deta	by Pł	Part II. Other significant conditions contributi		ot resulting in the	underlying cause gi	ven in Part I	. 23e. Did	tobacco use contrib	oute to the cause of death?
ord	w requir been sh should I	ted	gortic steno	5, 5,	pulmo	urry u	11001	1	Yes 2 No 3	3 ☐ Probably 4 ☐ Unknown
or Vital Records,	e la has je 2	Completed	anemic					24a. Was auto perf	ppsy pr ormed? de	fere autopsy findings available in for to completion of cause of eath?
tal	slcian: Th certificate rector, pag	0	25. Was case referred to medical				26. Place	1 Yes e of Death (Check only		□Yes 2□No
Z	is dir	To B	examiner? 1 Yes 2 No	l: 1 □ Inpatient	2 ER/Outpation	ent 3 DOA Ot	her	ursing Home 5 Res		r (Specify)
	ding Ph h. After th funeral		1 Natural 5 □ Pending	. Date of Injury (Month, Day Ye	28b. Time Injury	Wo			how injury occurre	d
Division	tten leatl ttor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	. Place of injury - building, etc. (S	At home, farm, s	M 1 []Yes 2□	28f. Location	(Street and Numbe wn, State)	r or Rural Route Number,
ō	e Hospital or A: 124 hours after of e Funeral Directiletely filled in by									
	Hos Fun ely	edical	29a. Certifier 1 ★ Certifying Physician (Check only one) 2 Medical Examiner: O at	n the basis of exa nd manner stated	amination and/or	investigation, in my	opinion, dea	ath occurred at the time	, date and place, a	nd due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	1/2		29c. Licen	se number 4 1 8	16	7	(Month, Day, Year)
	(5)			4		9	,		1/7	12008
-2	go Civi	1	30. Name and address of person who complete Chirles W. Pk-1/5	MD /	(Item 23a) (Type	50 (suns	Island	nd RD. A	nnepolis	/2008 MD 21401
	Sta Registi		31. Date filed (Month, Day, Year) JUL 0 8 2008	32. Registrar's	Signature				1	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Lottie B. Scarborough July 05, 2008 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
Under 1 Year | If Under 24 Hrs. Holy Cross Hospital Montgomery Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🖾 F Yrs 80 Director 07/11/1927 North Carolina 217-22-4502 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, Ite Madical Event is a rutified at 1X Yes 2 ☐ No Director MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 1401 Blair Mill Road # 302 20910 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? ☐Yes 24 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates Specify þ Specify: 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Health</u> Care d 2 should be filed with and Mental Hygie 7 is marked other tt Home Health Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be IInknown 2 Sally McGregor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2
Thent of Health an It. If item 27 is 1
Y or other trees. Mrs. Yolanda Logan / Daughter #302 Silver Spring, MD 20910 1401 Blair Mill Road Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page:
Department o
Important; If i
any Injury or
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 07/10/2008 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee Dong Montgomen 3401 Bladensburg Road Brentwood, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed Fluid Overload and burial-tra resulting in death) Last Due to (or as a consequence of). P.O. Box 68760, attending physician for use as the buria Physician/Medical Malnutrition IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Anasarca; Cholecystitis; Cholecystectomy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 🗆 No 1 ☐ Yes 2 X No 1 ☐ Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 X Natural 5 Pending Injury To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D19563 July 7, 2008 &C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Purnima Joshi, MD 1500 Forest Glen Road Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Sign State JUL 0 8 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Dav Ella June 29, 2008 Sanders 5:05 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly
If Under 1 Year 1 If Under 24 Hrs. Prince George's 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 218-14-3563 1 ☐ M 2 🔀 F 82 Maryland Director 04/16/1926 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 28a-f show Examiner must be notifled at ¥XYes 2 □ No P.G. Cheverly Director Md_{-} 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2900 Mercy Lane 20785 U.S.A. 'natural", or items 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.
African-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Š Specify Specify: American 3 □ Widowed 4 □ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12th Day Care Provider Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Merritt Sanders Ella Harrod 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Chase/Cousin 9610 Beverly Ave., Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. 7/8/08 Beltsville, Md. 21. Signature of Funeral Service Licensee 12. Name and Address of Facility & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 nau 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) was **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner certificate be executed the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2 □ Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Division or Vital Records, P.O. by the 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perform certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P this 27. Manne f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funera Certification: Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

YL___

31. Date filed (Month, Day, Year)

JUL 0 3 2008

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

+ cys

			1 - State of Maryland State of Maryland Registrar	•	rtificate of D			Reg. No. 2	008	23282
	Physicia	ın	1. Decedent's Name (First, Middle, Last)				Date of De Month	Day	Year	3. Time of Death
	/Medic	al .	Nancy B. Smith 4a. Facility Name (If not institution, give street and number)	1	4b. City, Town, or	Location of Death	June 2	_	y of Death	11:30 P M
	Examin	er			Takoma				gomer	v
_	Funeral		Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		lace (State or Foreign
	Director		577-48-7122 1□M 2気F 70	Yrs.	Worth's Days		July 15			h Carolina
	DU	-	Usual Residence of Decedent 10a. State 10b. County 10c. City.	Town or Lo	cation				1	0d. Inside City Limits
	f sho	ō	100.000	shing						NO Yes 2 No
	the r	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cour	ntry?
	3a o		2529 - 14th Street, NE Apt. 1		20018	3		Unit	ed St	ates
	death	Funeral	12. Was Decedent Ever in U.S.	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14. Ra Bl	ace - Americ	
36	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If tien Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination into the rediffical and once.	by Fu	11 Marital Status Armed Forces? 1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ☐ No I Yes, Give		1 □Yes 2√2 No	Specify:		Spec	ify: B1	.ack
21215-0036	hours tural"	ed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a. Deced	dent's Usual Occupa	ation		16b. Kind of	Business/In	dustry
<u>.</u>	in 72 n "na"	plet	(Specify only highest grade completed)	(Give life. l	kind of work done d DO NOT use retired,	turing most of work i)	ing			
212	giene giene er tha	Completed	Elementary/Secondary (0-12) 12 years College (1-4or 5+)	Hote	1 Employe			Priv		
9	e file al Hy dothe vent,	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle	, Maiden Surna	ıme)	
V a	Ment Ment arkec aric e	2	Clarence Jackson				e Smith		01.1.7	. 0 - 1 - 1
Maryland	12 sh h and 7 is m rraum		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a					DC 20018
e,	1 and Heaft em 27 ther 1		Marie Adams - Mother 20a. Method of Disposition 20b. Pla		sition (Name of matory or other place		Date	20c. Location		
altimore,	ages ent of t: If it y or o		1 Burial 24 Cremation 3 Removal from State	_		7/10	/08		Clint	on, MD
Ė	nit. P artme ortan injur		21. Squature of Funeral Service Lice		ematory Name and Addres			Tuneral		
ã	any per		Monday Commendate		4001 Benn	ning Road	, NE Wa	ashingto	on, Do	20019
			23a. Part Letter the disease, or complications that caused the death. shock a heart failure. List only one cause on each line.	Do not ent	ter the mode of dyin	ig, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
F	Physician		Immediate Cause (Final disease or condition							Onset and Death
	/Medical Examiner		resulting in death) Due to (or a. a conseque	nce of):	1	1 .				
	Exammer	_	Sequentially list conditions, if any, leading to firmisolate	one of:	unau	alle	Le la la la la la la la la la la la la la			
	rted nsit	nine	cause. Enter Underlying Cause (Disease or injury	AQ.						
	execu n and al-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a conseque	nce of):	١	_ /	Λ. 1	•		
68760,	Attending Physician: The law requires that the death certificate be executed radeath. Atter this certificate has been signed by the attending physician and ector: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edical	a closte de	urs	de plai	ule_	coliti	S		
68	rtifica ng ph as th	Medi	IF FEMALE:					- 12019	-	
Вох	ath ce ttendi or use	an/	23b. Was decedent pregnant in the past 12 months?	death 3	Ectopic pregnanc	:y			Date of delived Month	very Day Year
Ö	es that the death certifigned by the attending be detached for use as	Physician/M	1 ☐ Yes 2 ☒NO 9 ☐ Unknown	ath 5 L	Other (specify) _					
9.	that the		Part II. Other significant conditions contributing to death but not result	ing in the u	inderlying cause give	en in Part I.	23e. Did	tobacco use co	ontribute to	the cause of death?
g,	uires I sign	d by					1 🗆	lYes 2.∏XNo	3 ☐ Pro	bably 4 🗆 Unknown
000	w requir s been si should l	Completed					24a. Wa		b. Were aut	opsy findings available ompletion of cause of
æ	The lav te has age 2 a	шо					per	opsy formed? 2½ No	death?	2 No
<u>ita</u>	ian: rtifica stor, p	Be C	25. Was case referred to medical examiner?			26. Place of Dea				
<u>}</u>	hysic this ce il direc		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ E			4 🗆 Nursing F		sidence 6 🗆 (ify)
n o	ing P	ino	1 Natural 5 Pending (Month, Day, Year)	28b. Time o Injury	Worl	ryat k? Yes 2 □ No	28d. Describe	how injury occ	urrea	
<u>sio</u>	ttend death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home	ne. farm. st		ites Z 🗆 No	28f. Location	(Street and Nu	mber or Ru	ral Route Number,
Division of Vital Records,	i ji ft o	Certification: To	4 Homicide determined building, etc. (Specify))			City or To	own, State)		
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 ★ Certifying Physician: To the best of my know (Check only 2 Medical Examiner: On the basis of examinating the control of the basis of examinating the control of the basis of examinating the control of the control	rledge, dear on and/or in	th occurred at the ti	ime, date and place	e, and due to thurred at the time	e cause(s) and e, date and plac	manner as e, and due	stated. to the cause(s)
	the I	Medical	one) and manner stated. 29b. Signature and title of restriffer		29c. Licens			29d. Date sig		
	5 1 kg 12		255. Signature and the Signature	M	0 0	6381	4	6/-	30/2	08.
			30. Name and address of person who completed cause of death (Item	23a) (Tvne	Print)	Q009	+		1	
R	(3)		Padma Chirumamilla 7600 Carro			Park, M	D			
	Sta		31. Date filed (Month, Day, Year) JUL 0 3 2008							
	Regist	-								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 30, 2008 June 10:05 PM Annie Bell Stevenson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Kensington Nursing and Rehab. Center Montgomery Kensington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9–18–1924 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 579-26-1211 **Funeral** 1□ M 2 F Days Hours Min Director Spartanburg, SC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at DC Washington 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Modical Examines must be to 838 Jefferson Street NW 20011 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No ۵ Specify: Black 3 X Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Earselean Sullivan ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rudolph Stevenson (Son) 1523 Sweet Gum Lane Matthews, NC 28105 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or once. Fort Lincoln Cemetery 7/3/2008 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Fune I Service Livensee 22. Name and Address of Facility Fort Lincoln Funeral Home Brentwood, MD 20722 3401 Bladensburg Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or es e consequence of): Examiner Malnutrition Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the pest 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar P.O. Box 68760, ned by the of Vital Records, been signe should be s certificate has lirector, page 2 s After al or Attending I e Hospital of 24 hours at e Funeral D

the Maryland

Baltimore, Maryland 21215-0036

Division I Director: / completely filled in by

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Sharma, MD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical



JUL 0 3 2008

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Kensington, MD

29c. License number

D0064624

20895

29d. Date signed (Month, Day, Year)

JULY 02, 2008

08-05314 Kristen Trader

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23284 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 11, 2008 **Medical Examiner** 0339 hrs Kristen Trader 4a: Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director Country Maryland 217-92-8596 11/27/1963 1 M 2 X F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16 Kimberly Court 21146 USA Funeral 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces 1 Never Married 2 Married 2 X No Yes White 3 Widowed 4 X Divorced If Yes, Give Year Yes 2 X No specify: Specify: the Medical Examiner þ Pages 1 and 2 should be filed within 72 hours 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Beauty Supply Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Manager Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Trader Patricia Elliott and Mental ent of Health and Me int: If item 27 is ma r other traumatic ev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessi Hall/ Daughter 16 Kimberly Court Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, July 15, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 permit. Page:
Department o
Important:
injury or oth Baltimore, Maryland Metro Crematory 2008 Donation 5 Other Specify ²² Name and Address of Eacility Barranco & Sons, P.A. Severna Park Funeral 495 Gov. Ritchie Hwy, Severna Park, MD 211 21/Signature of Funeral/Service Licensee MD 21146 Approximate Interval Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause of each line. Between Onset and Medical Death Cardiac arrhythmia mmedian Cause (Final disease kaminer r condition resulting in death) Due to (or as a consequence of): b. myocardial fibrosis uentially list conditions, if any leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED PI line a-b,27, perME, g883 9/15/08 TT X UNPENDED attending physician or use as the burial Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Year Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 V Unknown Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? ✓ Yes 2 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: Other₄ Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 V Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred X Natural 1 Yes 2 No 5 Pending filled in by the 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 __ Could not be (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E July 11, 2008 hoder M. 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State 1 5 2008

ORIGINAL

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ernest Lloyd Thomas July 6. 2008 12:06 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Silver If Under 1 Year Holy Cross Hospital Spring
If Under 24 Hrs. <u>Montgomery</u> Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M M 2□ F Yrs. Director 16, 1925 220-12-3756 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notfiled at 1 ☐ Yes 2 ☐ No Director Maryland Olney 10f. Zip Code Montgomery 10g. Citizen of What Country? 10e. Street and Number 18301 Georgia Avenue 20832 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1943-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 → Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd 2 should be filed within 7 sith and Mental Hygiene.
27 is marked other than "r traumatic event, the Mental Elementary/Secondary (0-12) College (1-4or 5+) Certified CPA Hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Jessup Blair Thomas Nellie Mae Howard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Martha Rutherford/Niece 3118 Jennings Road, Kensington, MD 20895 item 27 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 July | 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or = 5 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2008 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W. Silver Spring, MD 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** stage disease or condition resulting in death) /Medical Due to (or as a consequince of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events iner Due to (or as a consequence of): The law requires that the death certificate be executed Exami burial-transi resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy ned by the atter Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 □ No Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 UNO 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending after death.

Director: Ald in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 2. To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064100 $M \cdot D$ July 6, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Smitha Bhikkaji, MD 31. Date filed (Month, Day, Year) egistrar's Signature JUL 0 7 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23286 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:30 PM 7/2/2008 Catherine L. Thompson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Caroline Denton Caroline Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗱 F Yrs 6/22/1925 Director 83 Washington, D.C. 220-12-3030 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notifiled at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 No Director MD Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6100 Westchester Park Drive #714 20740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Army College (1-4or 5+) Elementary/Secondary (0-12) Personnel Assistant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna F. Killigan 2 Milton F. Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5008 Stewart Ct., College Park, MD 20740 Teresa A. Brady, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 7/7/2008 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 xlus 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HOLANGOCARCINOMA THOUTH resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospice examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

that the death certificate be executed sician and burial-tran physician the attending pl the p signed to cate has page 2 s certificate or Attending Physician:

Box 68760.

P.O.

Division or Vital Records,

this funeral After

Medical Certification: To

To the Hospital within 24 hours a To the Funeral State

ours after death.

neral Director: #
filled in by the for death.

> 31. Date filed (Month, Day, 2008 JUL 0 7

28a. Date of Injury (Month, Day Year)

Registrar DHMH 17 Rev 1/2001

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check on onel

29b. Signature and

3 ☐ Suicide

29a. Certifier

5 Pending investigation

6 ☐ Could not be

determined

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

29c. License number

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

636 A

HOUSE

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(3

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Day **Physician** 2008^{Year} 2 10:30 PM Wayne B. Tharpe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis Hunder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 12, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** 12 M 2 □ F 225-94-3467 50 1958 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ital Madical Examples in the matter and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1874 Cabrini Ct. 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Landscaper Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Tharpe Hazel Stribling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ed Colantoni / Partner 1874 Cabrini Ct. Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 7/5/2008 Alexandria, VA 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service 6512 NW Crain Hwy. Bowie, MD 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acquired **Physician** Lamure disease or condition resulting in death) /Medical Due (or as a consequence of) **Examiner** Sequentially list conditions Examiner Disk to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 32 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy page performed 1 □Yes 2 No 1 ☐Yes 2 ZNo funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Phopatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

3 State

31. Date filed (Month, Day, Year) JUL 0 8 2008 Registrar

11115

29b. Signature and title of confifie



AAmc,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABRAHAN

2001

29c. License number

D56658

medical Partinous

29d. Date signed (Month, Day, Year)

ANNAPOLIS.

2008

md 21401

08-05007 Derrick Tabong

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

errick Tabong	}		For State	tate of Maryland /		tificate of		u Mentai		. No. 2	008 2328
Physic	ian/		egistrar . Decedent's Name (First, Midd	ile,Last)					2. Date of Death	Dav Year	3. Time of Death
edical Exam		T 4	DERRICK		TAB	ONG			June 29, 20	4c. County of I	0224 hrs
		4	 Facility Name (if not institution Sinai Hospital 	on, give street and number)]4	b. City, Town, or Baltimore (eatn	4c. County or i	Jean
Funera	1	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Excelent A DVI A NID)								
Directo	7	12	212-11-9362 1X M 2 F 22 Yrs. Months Days Hours Min. 9/15/1985 Following PART LAND Country)								
any		_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits								
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Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?							t Country?		
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ath wit items 2	Fineral		Marital Status Never Married 2 N	Armed Forces?		S. 13. Was	s Decedent of Hi es, specify Cuba	n, Mexican, Pu	erto Rican, etc.)	White,	
fter de	Y E		3 Widowed 4 Di	1 Yes 2	X No	1	Yes 2 X N	o specify:		Specify:	BLACK
hours a natura	3 I —		15. Decedent's Education (Sp				t's Usual Occupa ost of working lif			16b. Kind of Busi	ness/Industry
36 nin 72 s. than "-	Completed		Elementary/Secondary (0-12	College (1-4 or 5 4 yrs	D+)	STUDE	ENT			NONE	25
D 21215-0036 should be filed within 72 hou and Mental Hygiene.	2	3/	7. Father's Name (First, Middle					18.Mother's N	lame (First, Middle, M A MONIKAN		
2121 ould be fil Mental F marked	a a	0	SIMON TABO 19a. Informant's Name/Relation			19h Mailing	Address (Stre		r or Rural Route Num		, State, Zip Code)
O od D is	1	T	JULIA MONIKAN			1				IMORE, M	ARYLAND 21207
ore, ME	T.	- 1	20a. Method of Disposition 1 ABurial 2 Crematic	on 3 🗶 Removal from Sta		Place of Dispos crematory or otl	ition (Name of c ner place)	emetery,	Date	20c. Location - (City or Town, State
Baltimore, permit. Pages 1 at Department of Hee Important: If ite			4 Donation 5 Other	Specify:		MILY PI					, CAMEROON
Baltimore, ME permit. Pages 1 and 2 s Department of Health as Importants. If them 27		1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785								
Physicia	_	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and								
yamine	_		Immediate Cause (Final diseas	e (Final disease a. Multiple Injuries							
		- 1	or condition resulting in death) Due to (or as a consequence of): b.								
		힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause								
		EΙ	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
50, te be executed yysician and			d.								
30, te be ex sysician	burial	ĕ	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outco	me of nrec	nancy				23d. Date of	delivery
tox 68760, leath certificate be attending physic	e as the	an 2	23b. Was decedent pregnant in past 12 months?	1 Live birth		2 🔲 F	oldi dodaii	Ectopic p	regnancy	Month	Day Year
eath eath	lor us	Physician/Medical	1 Yes 2 No 9 Unknown g Unknown								
P.O. B es that the de igned by the	detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown								
cords, P.O law requires that has been signed b		ed by							24a. Was		Were autopsy findings available
cord	2 shou	Completed							autor perfo	osy p rm <u>ed</u> ? d	orior to completion of cause of death?
tal Reco sian: The law certificate has	r, page		25. Was case referred to medical 26. Place of Death (Check only one)								
of Vital Records, g Physician: The law require. After this certificate has been is	directo	mĭ	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other:								
of of ing Ph	uneral	<u>۱</u>	27. Manner of Death	28a. Date of Inj (Month Day Jun 29, 2008	jury Year)	28b. Time of 0130 hrs	Injury 28c. In	njury at Work? Yes 2 ✔ N	Driver auto	how injury occurr auto collision	
Division tal or Attendiins after death.	by the	<u>ij</u>	2 Accident	vestigation 28e Place of I			eet, factory, offic			Street and Number	er or Rural Route Number, City
Divis	filled in by the funeral director, page	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined 4 Homicide (Specify) Local Street 4 Homicide (Specify) Local Street								
D Hospital 24 hours	~		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
To the Hosp within 24 ho To the Fun	compl	Medical	one) 2 Medical E 29b. Signature and title of cert	and manner stated	amination 1.	ang/or investig:		ense number			ed (Month, Day, Year)
			200. Organization graphics or certification	well my			1	C.M.E.		June 29, 2	008
30. None and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
NO	1	أ	Melissa Brassell, Mi				Penn Street	, Baltimore,	MD 21201		
Reg	Sta		31. Date filed (Month, Day, Yea		ar s Signa						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistrarAmended #s 10e & 19b Per, <u>7/10/0</u>8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 27, 5:27 P.M Leon Thomas June 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 02/09/1931 7. Age (In yrs. last birthday)
77 Yrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** 1₽¥M 2□F Months Days Hours Min. 217-28-8242 Beltsville,Md. Director Hsual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1⊈Yes 2 No Director Md. P.G. College Park 10g. Citizen of What Country? 10e. Street and Number 51st. Ave. 10f. Zip Code 8001 5th street 20740 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White etc. 1 M Yes 2 No If Yes, Give 51 - 53 Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 ☐ Widowed 4 █ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be Samuel Thomas Annie Hebron ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mableton

Brickleridge Lane, Mable, Georgia 30126 19a. Informant's Name/Relationship (Type. Print) of Health Cheryl White/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Himportant: If Ite 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 07/10/08 | Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility on & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician a. Hypertension Years /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus, II Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Atherosclerosis Years and resulting in death) Last Due to (or as a consequence of) Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Stroke Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy page perform 1□ Yes 27 No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 KER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Cirector In by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide arter To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28998

31. Date filed (Month, Day, Year) JUL 0 3 2008 Registrar

Pritam S. Saini, M.D. 9101 Cherry Lane, Suite 211, Laurel, Maryland 20708 32. Registrar's Signaty

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

June 28,2008

Division of Vital Records, P.O. Box 68760,	al or Attending Physician: The law requires that the death certificate be executed expert death.
Record	rhe law requir
of Vital	Physician:
IVISION	al or Attending
	E .

		•	For State Registrar		State of	Marylar		artmen rtificat				ental Hyg	giene ()	08	23290
	Physici		1. Decedent's Name Joey Lee)							2. Date of Dea Month July	ıth	08 Year	3. Time of Death 9:10 A M
	/Medic Examin	er	4a. Facility Name (If r	not institution, give		ber)		4b. City,		Location o	of Death		4c. Cou	inty of Death	
	uneral irector		5. Social Security Nur 216-13-017 Usual Residence of D	¹⁰	x X M 2□F	'. Age (In yrs.	. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day NOV • 1,	1986	9. Birth Cou West	place (State or Foreign Intro) Virginia
1215-0036 within 72 hours after death with the Maryland and	Sa-f show	ctor	10a. State	Garrett			ity, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
ath with th	e 23a or 21 nust be no	ral Dire	10e. Street and Numb						1531				USA	of What Cou	
036 ours after de	al', or item Examinació	Completed by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Deced Armed For 1 Tyes : If Yes, Give Year or Da	ces? 2 🔀 No		Was Deced If Yes, specification		spanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)		Race - Amer Black, White ec <i>ify:</i> Wh:	, etc.
21215-0036 Id within 72 hours affoliene.	d within 72 h giene. ir then "natu the Medica	mpleted	(Specify Elementary/Second	5. Decedent's Edu only highest grad dary (0-12)	cation le completed) College (1-	4or 5+)	life.	dent's Usua kind of wo DO NOT us icapp	rk done d se retired)	urina mos	t of workin	ng	16b. Kind o	f Business/li	ndustry
Maryland 2 d 2 should be filed v	ie marked other than aumatic event, the M	3e	17. Father's Name (F Richard Up				nana	тсарр			er's Name	(First, Middle,	Maiden Sun	name)	
ore, Mar	if items 21 is marked other than "natural", or items 23a or 28a-f show or other traumatic event. the Madical Examinar must be notified at	-		th/Guard	ian	20b.	7318	Crane	svil	le Ro	d., F	Poute Numbe riendsv ate	ille,	MD 2	1531
Baltimore,	permit. Pages 1 end 2 Department of Health a Important: if item 27 is any injury or other tra 2006.		20a. Method of Disposition 1 General 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Blooming Rose Cem. July 3, 2008 Friendsville, MD 21. Signature of Functal Service Library 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536												
/M Exa	edical ledical aminer	Examiner	23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death) Dequentially list condition in the shock of any, leading to immediate. Enter Under Cause (Disease or in that initiated events resulting in death) La	intions, nediate ring jury	Due to (c	or as a conse	quence of):			, such as		r respiratory an			Approximate Interval Between Onset and Death
P.O.	led by the ettending physicien and detached for use es the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 9 □ Unknown Part II. Other signific	oregnant onths?	d	nth 2 □ Fet untattime of o wn	nancy al death 3 [death 5 [Ectopic pr	pecify)	n in Dort		23a Did to		Date of delivered to the state of the state	very Day Year the cause of death?
Vital Records, sician: The law requires t	is been sign 2 should be	Completed by	Chron	e pr	€vm	en ra	7					1 ☐ Y	es 2 2 4 an 24	3 ☐ Pro	obably 4 Unknown
of Vital R	nis certificate he I director, page	Be	25. Was case referre examiner? 1 ☐ Yes 2 ☐ N		Hospital:		7		Othe			perfor 1 ☐ Yes Check on vo	med? 2 S No	death? 1 ☐ Yes	2 1 No
Vivision of or Attending Phy fler death.	Director: After the	Certification: To	27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	28a. Date o (Month	f Injury , Day Year)	28b. Time o Injury	f 2	28c. Injury Work	4 🗆 INL	No 2	28f. Location (S City or Tow	ow injury od	curred	ral Route Number,
To the Hospital within 24 hours a	To the Funeral Completely filled	edlcal	29a. Certifier 1 (Check only 2 one)	☑ Certifying Phy ☐ Medical Exami	sician: To the ner: On the ba and mann	sis of examin	owledge, deat ation and/or in	h occurred vestigation	at the tim	e, date an inion, dea	nd place, a ith occurre	and due to the o	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)
Tot	Tol	N .	29b. Signature and the 30. Name a address	for	ompleted a se	of death (Ite	m 23a) (Tvoe	1	C. License	number	69	/		gned (Month	Day, Year)
	Sta Registr		Sotiere S 31. Date filed (Month	avopoulos Day, Year)	s, M.D.		North 4	-	treet	, Oa	kland	d, MD	21550		

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2008

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		1	For State Of Maryland State Registrar	Certificate			Reg. No.	08	23291
	ysicia	n	Decedent's Name (First, Middle, Last) Mark Stanley Uphole			2. Date of Dea Month July		Year 0 8	3. Time of Death 7:56 A.M
	<i>l</i> ledica amine		a. Facility Name (If not institution, give street and number)	4b. City, T	own, or Location of Death		4c. County		
	amme		Garrett County Memorial Hospita	al Oakl	Land		Garr	ett	
Fun Direc	-	1	Social Security Number 6. Sex 7. Age (<i>In yrs. la</i> 215–26–6256	ast birthday) If Under 1	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birt (Month, Day	h y, Year) 8 1930	Coun	ace (State or Foreign try) 1and
	Clut	-	sual Residence of Decedent			rep 10	3 1930	nary	Zand
yland	ä		Da. State 10b. County 10c. City	, Town or Location				10	d. Inside City Limits
Man	fied .	ğ	MD Garrett Dee	er Park					1 ☐ Yes 2 X No
h the	not .	Director	De. Street and Number	10f. Zip 0	Code		10g. Citizen of W	/hat Coun	try?
th wit	et pe	a	125 Upperman Road	215	550		United	State	es
deal deal	ı ı	Funeral	1. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decede	ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto	ecify Yes or No	. 14. Race	- America	
aryland 21215-0036 should be filed within 72 hours after death with the Maryland not Mental Hygiene. s marked other than "natural", or Items 23a or 28a-f show	u u		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1 □ Yes 2		, , , ,	Specify.		
DOCS nours	EX :	d b	3A Widowed 4 Divorced Year or Dates:	10 5 1 5 1				MILT	
.72 h	dica	ete	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual (Give kind of work	Occupation done during most of work retired)	king	16b. Kind of Bu	siness/inc	lustry
withir than	e M	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 1 2		ipment Opera		Coa1	Compa	any
Hygie ther	밭		7. Father's Name (First, Middle, Last)	mout, Equi	18. Mother's Nam			-	
and be set o	e e e	m	Laymond Uphole		Minnie	Har	tsell		
Maryland 21215-0036 at 2 should be filed within 72 hours aff th and Mental Hygiene.	mati	۵.	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Ru			State, Zip	Code)
	trau		David Harvey, P.O.A.	I -	dford Rd., 0		-		
ore, Miss 1 and 2 of Health 8	other traumatic	Ý		ace of Disposition (Name emetery, crematory or off		Date	20c. Location -		wn, State
Pages 1 (nemt of Herm	yor	I	11 ABurial 21 ICremation 31 IHemoval from State 1	er Park Ceme	i i i	/2008	Deer Pa	rk, l	MD
Baltimore, permit. Pages 1 a Department of Hee Important: If Item	any Injury or	1	21. Signature of Funeral Service Licensee		Address of Facility A. Burdock				
Dep Dep G	any		Katherine Surity	David 21 N	A. Burdock Second St.,	Oaklan	ноте, Р d. MD 21	550	
Physic /Med Exam	ical		23a. Part1. Enter the disease, or complications that aused the death shock, or heart failure. List only one cause direct inc. mendiate Cause (Final disease or condition aused in aused the death inc. Due to (or as a consequence of the condition aused in	Zyaccev	hut (ow	Eup 4	sang	r.]	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, fairly, leading to immediate abuse. Enter Underlying abuse (Disease or injury hat initiated events esulting in death) Last						
68760, ficate be exe		edical Ex	Due to (or as a consequence)	ence of):					
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	ched for use a	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknow	death 3 ☐ Ectopic pre			23d. Dat	e of delive nth	ery Day Year
, P	deta		art II. Other significant conditions contributing to death but not resu		use giyen in Part I.	23e. Did t	obacco use conti	ribute to th	ne cause of death?
rds quires n sign	ad bi	d by	Congestive H	aux Ja	ilve.	1 🗆 '	Yes 2 □ No	3 Prob	ably 4 □Unknown
Vital Records, stolan: The law requires t	C/	Completed				24a. Was	an 24b. V	Were auto prior to cor death?	psy findings available npletion of cause of
al F	, pag					1□ Yes	20 No	Yes	2 □ No
Vit Vital siclar certif	rector	Be	25. Was case referred to medical examiner?		26. Place of Dea				
OF Phys	ral di	2	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ Inpatient 2 ☐ Inpa	ER/Outpatient 3☑ DO/ 28b. Time of 28	4 ☐ Nursing H		dence 6 Oth		y)
On o	fune	io	Natural 5 Pending (Month, Day Year)	Injury	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	Log. Describe	now injury occurr	Cu	
Division or Hospital or Attending Phys. 24 hours after death. P. Funeral Director: After this	d in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At no building, etc. (Specify	me, farm, street, factory,		28f. Location (City or To	Street and Numb wn, State)	er or Rura	l Route Number,
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Examination on the basis of examina and manner stated.						
To the within	com	Ž	29b. Signature and little (cepitter		License number		29d. Date signe	d (Month,	Day, Year)
		5	1 out		D23979		79.8		
		-	30. Name and address of person who completed cause of death (Item	23a) (Type, Print)					

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

- 9 2008

Robert A. Goralski, M.D., 311 N. Fourth Street, Oakland, MD 21550

32. Registrar's Signature

Physician /Medica Examiner

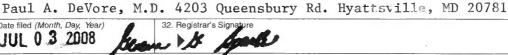
Funeral Director

	Plea	se Type or						•		-	ble.	
	for State	State o	f Maryland			r Health of Death			gien Reg. N	0.0	0 0	22202
	Registrar 1. Decedent's Name (First, Middle	e, Last)		0071	mouto c	Douth		2. Date of De	ath	20	U O	3. Time of Death
an ai	Ernest	Vea1						June 2		ay 2008	Year	10:49 A ^M
er	4a. Facility Name (If not institution		mber)	4	4b. City, Tow	n, or Location	of Death	o dire		c. County		
Ų.	St. Thomas Mon					sville				Prin		eorge's
	5. Social Security Number	6. Sex 1 ★ M 2 ☐ F	7. Age (In yrs. la		Months Da	ar If Under ys Hours	Min.	8. Date of Bir (Month, Da	th ay, Yea	r)	9. Birti Co	nplace (State or Foreign untry)
	423-44-0271 Usual Residence of Decedent		71	110.			<u> </u>	Sept 28	3,_1	936	Ala	bama
	10a. State 10b. County		10c. City,	Town or Loca	ation							10d. Inside City Limits
ctor	Maryland Princ	e George'	s Hy	/attsvi	ille							1 Yes 2□No
)ire	10e. Street and Number				10f. Zip Coo	е			10g. (Citizen of \	What Co	untry?
<u>ra</u>	4922 LaSalle F	Road			2078	34			τ	nite		
nne	11. Marital Status	Armed Fo		n U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.))-	14. Rad Blad	e - Ame ck, White	ncan Indian, e ^{, etc} African	
y F	1 Never Married 2 Marri 3 Widowed 4 Divorced	ied 1 □ Yes If Yes, Gi Year or D	ve	10	□Yes 2√	No Specify	<i>:</i>			Specif		American
ed	. 15. Decedent	t's Education	110	16a. Decede	nt's Usual Oc	cupation			16b.	Kind of B	usiness/l	ndustry
ple	(Specify only highes	st grade completed) College (1-4or 5+)	(Give ki life. DC	ind of work do O NOT use re	ne during mo: tired)	st of worki	ing				•
Be Completed by Funeral Director	4 years			Lat	orer					Pri	vate	
Be (17. Father's Name (First, Middle,	Last)						(First, Middle	,		ne)	
မ	Arnold Veal							€ B. Ja				
	19a. Informant's Name/Relationsl Crystal Houck	1 () /	-er					al Route Numb Hyattsi				
	20a. Method of Disposition							Date				Town, State
	1 ☐ Burial 2XXX remation	20a. Method of Disposition Date Date 20c. Location - City or Town, State										
	21. Signature of Funeral Selvice		A Liee		_			ewart I	une			
	1 Day St	16.10	1					NE Was				4. 1900
	23a. Part1 Enter the disease, or shock or heart failure. List	complications that o	caused the death.	Do not enter	the mode of	dying, such as	s cardiac o	or respiratory a	arrest,			Approximate
	Immediate Cause (Final disease or condition		ne cause on each line. Arteriosclerotic Cardiovascular Disease Interval Between Onset and Death years							Onset and Death		
	resulting in death)	Due to	Due to (or as a consequence of):								-	
	Sequentially list conditions.	b										
ine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to	Due to (or as a consequence of):									
хап	that initiated events resulting in death) Last	c	(or as a conseque	ence of):						· · · · · · · · · · · · · · · · · · ·		
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edic		0							-			
Completed by Physician/Medical Examine	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregnan							23d. Da	ite of del	ivery
icia	in the past 12 months? 1 □ Yes 2 □ No		birth 2 □ Fetal on nant at time of dea		Ectopic pregn Other <i>(specif</i>)					Mo	onth	Day Year
hy	9 Unknown							-				
β	Part II. Other significant condition Respiratory Fa		eath but not resuli	ting in the und	lerlying cause	given in Part	I.					the cause of death?
ted								1	Yes	2 No	3 🗆 Pr	obably 4 Unknown
nple	Chronic Obstru	ctive Lur	ng Diseas	se				24a. Was	psy		prior to d	topsy findings available completion of cause of
S								perf 1∐ Yes	ormed		death? 1 ☐ Yes	2□No
Be	25. Was case referred to medical examiner?	Hospital:		5/5	-5	Other:		n (Check only				
٠ <u>.</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date		R/Outpatient 28b, Time of		njury at Work?		me 5 Res 28d. Describe				cify)
tion	1 Matural 5 □ Pendin 2 □ Accident investig	9 '	nth, Day Year)	Injury		Work? 1 ∐ Yes 2 ⊑				,,		
ifica	3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place	of injury - At hon	ne, farm, stree	et, factory, off	ice		28f. Location	Street	and Numi	ber or Ru	ıral Route Number,
Sert	- Inditione	Dulid	ing, etc. (Specify)					City or To	wn, St	a(0)		
Medical Certification: To	(Check only 2 Medical	ng Physician: To the Examiner: On the b	pasis of examination	ledge, death on and/or inve	occurred at the	e time, date a	and place, eath occur	and due to the	cause , date a	(s) and m	anner as	s stated.
Medi	one) 29b. Signature and title of certifie	and mar	nner stated.			ense number		1				
	23D. Signature and title of certifie	an Oc	1/ /		D018					_		h, Day, Year)
	" Buch	ansec	VOU	T	DOT	JJ		1	-	une	۷0,	2000

State Registrar

31. Date filed (Month, Day, Year)

JUL 0.3 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05006 2008 23293 State of Maryland / Department of Health and Mental Hygiene Ma Elisa Cuevar Villanueva Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day June 28, 2008 2324 hrs Medical Examiner Maelisa Cuevas Villanueva c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Howard Columbia Howard County General Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Country Min. Days Hours Months 07/26/1963 Director Honduras None 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 Yes 2 No s 23a or 28a-f show a Ellicot City Howard Mddeath with the Maryland Directo 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number Honduras 21043 4956 Webbed Foot Way 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican; etc.) White, etc. must be Armed Forces? 1 X Never Married Yes þ Specify: 1 X Yes 2 No specify: Honduras Hispanic Give Yea narked other than "natural", c 3 Widowed Divorced filed within 72 hours after ₫ 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 House Keeper 9Th permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marina Villanueva Garay Marco Tulio Cuevas marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4956 Webbed Foot Way, Ellicot City, Md. 21043 t: If item 27 is other traumatic Q Domingo Villanueva / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Itimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/08/08 Honduras General Cemetery mportant 4 Donation 5 Other Specify: 22. Name and Address of Facility 21 Ignatur of Funeral Strvice Mason Funeral Services 5801 Cleveland Ave. Riverdale, Md 20783 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. E iter the disease, or Between Onset and **Physician** one cause on each line. List only failure Death Medica a. Multiple Injuries Immedi te Ca (Final disease *xaminei Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED **AMENDED** e attending physician for use as the burial -The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If ves. outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death Live birth 2 past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 1 Yes 2 ✔ No 3 Probably 4 Unknown þ σ. Completed 24b. Were autopsy findings available Division of Vital Records. 24a Wasan page 2 should been prior to completion of cause of autopsy performed? death? has 1 Yes Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medica the Hospital or Attending Physician: hin 24 hours after death. director, Be examiner? Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Hospital: DOA this 1 V Yes မ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death Passenger auto auto collision Certification: Jun 28, 2008 2228 hrs 1 Yes 2 V No 1 Natura Pending Fo the Funeral Director: completely filled in by the Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by Could not be 3 or Town, State) Route 1 and Lincoln Drive, Jessup, MD Suicide (Specify) Major Road / Highway Δ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie June 29, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, Yea JUL 0 3 2008 32. Registrar's Sign State 0

ORIGINAL

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Registrar

JUL

OCIVIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month June 2008 2:39 P Ralph Wright 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Georges Clinton If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Wash., D.C. Date of Birth (Month, Day. 1**X** M 2□ F 579-54-8027 Sept. 19, 1944 63 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Capital Heights MD 1X Yes 2 No Prince Georges 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5804 Jefferson Heights 20743 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status Yes 2☐ No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ₺ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther L. Bridges Ralph C. Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig Code) 2031 2nd St. N.E. Washington, D.C. 20002 Jacqueline Wright/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) June28,2008 Landover, Md. Harmony Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc MD 3831 Georgia Ave. N.W. Washington, D.C. 20011 278 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preumoma disease or condition resulting in death) Unknows Due to (or as a consequence of): renal UTKnowy Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1□ Yes 2 ☑ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Director

þ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit ed by the a detached f signed I To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Physician/Medical

þ

Completed

Be

၉

Certification:

Medical

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

29a. Certifier

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier In Farh 29c. License number D43446

29d. Date signed (Month, Day, Year) 6.22.08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Are Suit 3-32 silverspring MD 20902 9801 Georgia MA ROINTAN FARAITIFAR

State Registrar 31_ Date filed (Month, Day, Year) 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Bernice Wesley July 3,	
Bernice Wesley July 3,	2008 6:03 a M ic. County of Death Montgomery 19. Birthplace (State or Foreign Country)
4a. Facility Name (If not institution, give street and number) Arcola Health & Rehab. Center Silver Spring 5. Social Security Number 094-14-0678 Usual Residence of Decedent 4b. City, Town, or Location of Death 4b. City, Town, or Location of Death 4b. City, Town, or Location of Death 4c. City, Town, or Location of Death 4d. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. City, Town, or Location of Death 4c. City, Town, or Location of Death 4c. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death	Montgomery 9. Birthplace (State or Foreign Country)
Funeral Director 5. Social Security Number 094-14-0678 6. Sex 1	9. Birthplace (State or Foreign Country)
Funeral Director 5. Social Security Number 094-14-0678 6. Sex 1 M 2X F 7. Age (In yrs. last birthday) Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Dec. 29, 1	9. Birthplace (State or Foreign Country)
Director 094-14-0678 Usual Residence of Decedent 094-14-0678 1	
0	1920 New York
10a. State 10b. County 10c. City, Iown or Location	10d. Inside City Limits
War I and Mary I and M	1 ☐ Yes 2 ☐ No
Nontgomery Chevy Chase	
된 경우 기계 10e. Street and Number 10f. Zip Code 10g. C	Citizen of What Country?
8100 Connecticut Avenue, Apt. 602 20815	USA
Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10f. Zip Code 10g. Cip Code 10	14. Race - American Indian, Black, White, etc.
2 2 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:	Specify: White
3 ₩ Widowed 4 Divorced Year or Dates:	
1 1 1 1 1 1 1 1 1 1	Kind of Business/Industry
15. Decedents Succession Successi	
N P S S S S S S S S S S S S S S S S S S	Decialty Advertising
Tr. Father's Name (First, Middle, Last) Lewis Berk Gaby Bass	
Lewis Berk Gaby Bass 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City	Town Chats 7in Code
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City 9406 Bruce Drive, Silver Spring,	•
	Location - City or Town, State
1 Rurial 2 To Cramation 3 Ramoval from State	Eccation - Oily of Town, State
1 Burial 2xi Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 2008, Ale	xandria, Virginia
20a. Method of Disposition Date 20c.	Iome Inc.
500 University Blvd, W., Sil	ver Spring, MD 2090
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition Myocardial Infarction	sudden
/Medical resulting in death) Due to (or as a consequence of):	
Examiner Sequentially list conditions, b. Coronary Artery Disease	years
D i it any, teaching to initire diate.	
Se Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to	
in the control of the	
23c. If yes, outcome of pregnancy the performance of the performance o	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Bay roa
the table of the table of the table of	use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
Hypertension 1 Yes	2 No 3 Probably 4x Unknown
Hypertension The law requires to a specific statement of the law requires to a specific statement of the law requires to a specific statement of the law requires to a specific statement of the law requires to a specific statement of the law requirement 4b. Were autopsy findings available prior to completion of cause of	
performed: 1 □ Yes 3434	? death?
Use State of Death (Check only one) 25. Was case referred to medical examiner? Hospital:	
25. Was case referred to medical examiner? 1	6 ☐ Other (Specify)
24. Was all autopsy performed 1 Yes 2 XXX 25. Was case referred to medical examiner? 1 Yes 2 XXX 1 Yes 2 XXX 26. Place of Death (Check only one) 1 Yes 2 XXX 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how in Work?	jury occurred
5 ਦੇ ਜ਼ੁੰਦੂ to 1 ☑ Matural 5 ☐ Pending (Month, Day, Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	
28d. Describe how in property to the property of the property	and Number or Rural Route Number,
28d. Describe how in page 15 p	-,
29a. Certifier 29a. Certifier (Check only Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause	e(s) and manner as stated.
and manner stated.	and place, and due to the cause(s)
£ £ £ \$ \$\psi\$	Date signed (Month, Day, Year)
29a. Certifier Check only one) 29b. Signature and title of certifier 29c. License number 29d. License number 29d. License number 29d. License number	
A continue of the part of the	July 3, 2008
30. Name and address of nerson who completed cause of death (Item 23a) (Type Print)	
DS2552	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND#3perME, 7-3-08, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Пач Month 05:28 **Physician** Walker, Jr. July 1 2008 John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min. 1**™**M 2□F Months Days Virginia 17, 1916 Director 578-12-8351 91 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Medical Examirer must be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4503 Dahill Road 20906 IISA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 哲Yes 2 □ No If Yes, Give Year or Dates: 1942-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 S No Specify à Specify: 3 Midowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Print Shop Manager Printing is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) be t Be Edgar John Walker, Sr. Mary Catherine Shotroff ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. Ronald J. Walker/Son 4311 Mahan Road, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State July 1 ☐ Burial 2 🖾 Cremation 3 🖾 Removal from State Metropolitan Crematory Alexandria, Virginia 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Firanceand Address Colimns Funeral Home Inc 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a sest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** I wer Castrointostinal Blos Due to (or as a consequence of): /Medical Examiner Right Hip Fracture Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): 50 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ed by the a 1 Tyes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à Coronary Artery Disease, Renal Insufficiency 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 2 s performed 2 X No 2 🗆 No 1 ☐ Yes 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∭XYes 2 ☐ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this, Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury Fall due to loss of balance death. 1 ☐ Yes 2 X No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6/02/08 1400 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4503 Dahill Road determined 4 Homicide Home Silver Spring, MD 20906 29a, Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number jandra Delistatlis, D59980 0 July 1, 2008

State Registrar

31. Date filed (Month, Day Year)

Sandra Delistathis, MD

8600 Old Georgetown Road, Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Val Ker, Edgar

			For State Registrar		aryland / i	•	tificate of	Death		Reg. N	0000	3 23	329
	Physicia	an	Decedent's Name (First, Middle						Date of De Month	D	ay Year	3. Time o	
	/Medic		Anna B.	Wal					July		2008	7:11	P M
2	Examin	er	4a. Facility Name (If not institutio					or Location of Deal	th		c. County of Deat		
4.			Washington Adve		cal e (In yrs. last bii	rthday)	Takoma If Under 1 Year		6. 8 Date of Bi		lontgomer	hplace (State	or Foreign
ı	Funeral Director		579-62-0850 Usual Residence of Decedent	1 M 2 F	63	Yrs.	Months Days	Hours Min.		945	r) Fine	astle,	
	and and		10a. State 10b. County		10c. City, Tow	n or Loc	ation					10d. Inside (City Limits
	Mary -f she	to	MD Prince	George's	Capit	o1 I	leights					₩∏Ye	s 2∐No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What Co	untry?	
	h witt	a D	916 Flores St	reet			2074	3		Uni	ted Stat	es	
	ems ems	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or N	0-	14. Race - Ame Black, White		
215-0036	within 72 hours after death with the Maryland spen than "natural", or items 23a or 28a-f show the Macilical Examiner must be notified at	þ	1 □ Never Married 2 □ Mar 3 □ Widowed 4 ∏ Divorced	ried 1 □Yes 2 📉1	No		□Yes 2XNo		10 1 110411, 01017			Black	
ה	72 hc 'natu	etec	15. Deceder (Specify only highe	nt's Education est grade completed)	16a	. Deced	ent's Usual Occup	pation during most of wo d)	rkina	16b.	Kind of Business/	Industry	
7	filed within 72 Hygiene. other than "nal ent, Ibe Malic	Completed	Elementary/Secondary (0-12)	College (1-4or 5				•	9				
7	lled w Hygie ther t	ပိ	17. Father's Name (First, Middle,	Lact)	Sec	curi	ty Offic	18. Mother's Na	mo /First Middle		SSA		
⊆ _	d d c	Be c	Minor Walter						e Welch	s, marge	an ourname)		
	2 should and Mer is marke aumatic	မ	19a. Informant's Name/Relations		191	Mailin	n Address (Street			her City	y or Town, State, 2	Zin Code)	
Ž	s 1 and 2 should f Health and Mer tem 27 is marke other traumatic		Raylene Walls								ghts, MD		
ē,	es 1 a of Hei		20a. Method of Disposition		20b. Place o	of Dispos	sition (Name of atory or other pla	ce)	Date	20c.	Location - City or	Town, State	
Ĕ	Pag nent int: I		1)∏ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Fort 1	Linc	oln Ceme	tery 7/1	0/2008		entwood,		
saltimore,	permit. Departr Importa any Inju		21. Signature of Funeral Service	Licensee		22.	Name and Addre	ess of Facility ${ m Fo}$	rt Linc		Funeral		
	9 Q T 9 9		Turil Shon	<i>U_</i>							wood, MI	20722	
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that caused only one cause on each lir	the death. Do ne.	not ente	er the mode of dyi	ng, such as cardia	ac or respiratory	arrest,		Approxima Interval Bo Onset and	ate etween
F	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. A+6	crosit	LYU	4c Ca	8 diovas	cular	di	Sean	Oliset and	Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	` ^		_ / `.				
		er	Sequentially list conditions,	b	a consequence			holo	Cardil				
	uted 1 Insit	Ë	Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	\$ 500.00 (01.00)	a composition	J./.							
ŕ	exec	Examin	resulting in death) Last	Due to (or as	a consequence	of):			<u> </u>				
68760,	rtificate be executed ng physician and as the burial-transit	Medical		d									
	rtifica ng ph as th	Ned	IE EEMALE.										
Š n	death ce e attendii d for use	an/N	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Fetal deatl	h 3□	Ectopic pregnanc	cv			23d. Date of de	-	V
5	w requires that the death cer been signed by the attendir should be detached for use	Physician/	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify) _				Month	Day	Year
7.	requires that the reen signed by th hould be detache		Part II. Other significant conditi	ons contributing to death b	ut not resulting i	n the un	derlying cause giv	ven in Part I	23e. Did	tobacc	o use contribute to	the cause o	f death?
ďŠ,	sign d be	d by	3				aonymg dadoo gm	7011 11 1 11 11			2 □ +No - 3 □ Pi		
cord	v requ	ete			***				24a. Wa		Oth Ware or	stones finding	e available
ω.	e lay has ie 2	Completed			-				auto	opsy formed?	prior to death?	utopsy finding completion of	cause of
	ilcian: Th certificate rector, pag	O O	25. Was case referred to medica	1				26. Place of Do	1 □Yes eath (Check only		1 ☐ Yes	3 2 □ No	
5	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ ₩6	Hospital:	ent 2 LER/O	utpatien	t 3 DOA Oth	nor:			6 □Other (Spe	ocify)	
ם י	iding Physician: th. : After this certifica ! funeral director, p	L:	27. Manner 1 eath	28a. Date of Inju	ıry 28b.	Time of Injury	28c. Inju	ry at	28d. Describe			Olly)	
000	endir eath. or: Af	atic	1 Accident 5 Pendir	gation	,, roui)	,,		Yes 2□No					
UIVISION	or Att	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 28e, Place of Inji	ury - At home, fa c. (Specify)	arm, stre	et, factory, office		28f. Location City or To	(Street own, Sta	and Number or Ri ate)	ural Route Nu	ımber,
ָ ב	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	O	29a. Certifier 1 ertifyi	ng Physician: To the best	of my knowledg	e, death	occurred at the t	ime, date and plac	ce, and due to th	e cause	e(s) and manner a	s stated.	
	the Horin 24 the Fu	Medical	one)	Examiner: On the basis o	of examination a ated.	nd/or inv		<u> </u>	curred at the time		<u> </u>		
	Vitt Con	2	29b. Signature and title of certifie	1 4 /	MO		29c. Licens	0 60 lo	0		Date signed (Mont		
	C. E		30. Name and address of person	who completed cause of d	leath (Item 23a)	(Type, F				44	20913		
	Sta		31. Date filed (Month Day Year)			1	- 1		, ,				
	Registr	ar	JUL U O COOL	bosen ky	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Box 68760. 0 ۵. Records, Vital Hospital or Attending Physician: oţ within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral Division To the

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

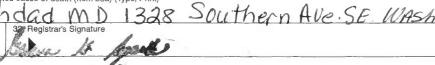
(Check only one)

29b. Signature and title of certific

31. Date filed (Month, Day, Year) JUL 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 51520

29d. Date signed (Month, Day, Year)

7-15-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12, 2008 0501 Myrtle M Weltman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY WHMS-Memorial Campus If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Dec 14, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🙀 F 1917 Country) Director 213-22-2926 90 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be not the once. 10a. State 10c, City, Town or Location 10d. Inside City Limits 10b. County Cumberland MD Allegany ty∏Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21502 USA 730 Furnace Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. Specify: 3X Widowed 4 □ Divorced white Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) iaborer Celanese Corp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Piper Gordon Edgar Gordan ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
220 Rolltimore Ave Ant Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Jean Byrne daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/15/2008 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home, PA 21. Signature of Funeral Service Licens 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immedial Cause (Final diseas r condition resulting in death) **Physician** Aspiration neumoni /Medical Due to (or is a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the Innerial director, page 2 should be detached for use as the burial-transit in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours aff To the Funeral D 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

C.

500 Memorial Ave. Cumberland, MD.

30. Name and address of person who of mpleted cause of death (item 23a) (Type, Print)

32. Registrar's Signature

lobustiano Barrera

JUL 1 8 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 2008 Ruth Ann Zlatos 10:15 AΜ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner New Carrollo.

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Min. | Charles | Min. | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Charles | Cha Prince George's 6104 Lamont Dr. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** . 1924 Indiana 1 ☐ M 2 **X** F 83 303-24-1109 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Prince George's New Carrollton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20784 USA 6104 Lamont Dr. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Editor, Army Chief of Staffs U. S. Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver Marley Chloe Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21032 824 Miner Rd. Crownsville, MD John J. Zlatos, Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/11/2008 Our Lady of Sorrows Hillside, Il 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service L Beall Funeral Home ronea 6512 NW Crain Hwy. Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician oronas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of : Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2₺ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? page 2 certificate has 1∐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2K No 2 ER/Outpatient 3 DOA 1 | Inpatient Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4566

State Registrar

31. Date filed (Month, Day, Year)

CC

JUL 0 8 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Acevedo F /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner hmor Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Funeral Min. 217-24-6169 1 ☐ M 2 X F Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at m.D 1 es 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21227 U.5.A Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Mo Specify. 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) government Elementary/Secondary (0-12) College (1-4or 5+) th. GRAde USTOdiAn NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ORDAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ViA ROXADA RANDALISTOWN AD. 21133 Rd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐Burial 2 ☐Cremation 3 ☐Removal from State Wood/AWA 4 Donation 5 ☐ Other (Specify) Was d JAWA DR. BATTO ATD Jul 22. Name and Address of Facility ure of Funeral Service Licens BETTE FUNERAL HOME 1129 N. CARDLINEST. BASTIMORE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (o as a consequence of): **Physician** Mikediat disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit ICK OSIS Due to (or as a consequence of): signed by the attending physician the detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 21110 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, cate has by page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

and

28a-f show

Baltimore, Maryland 21215-0036

State Registrar

29c. License number 29d. Date signed (Month, Day, Year)

32. Registrar's Signature

			For	State of Ma	aryland / I	Department of		d Mental Hy	giene		
			1 - State Registrar 1. Decedent's Name (First, Middle, La	oot)		Certificate o	f Death	2. Date of De	Reg. No. 2	008	23302
	Physici			HARLES	AMER	EIHN		Month	18,20	Year 0.8	3. Time of Death 7:15A
may sta	/Medic Examir		4a. Facility Name (If not institution, gi				, or Location of De		4c. Cour	nty of Death	
- '			GILCHRIST HOS 5. Social Security Number 6.				COWSON ar If Under 24 H	rs 9 Data of Bi		ALTIM	ORE
П	Funeral Director			1 M 2 F 7. Ag	e (In yrs. last bi 57	Yrs. Months Day			ay, Year) -1950	Coun	try) YLAND
	nd w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Location					Od. Inside City Limits
	Maryla f sho	to		TIMORE	Toc. City, Tow		ARKVILLE	Ξ			1 □ Yes X □ No
	h the	irec	10e. Street and Number		<u> </u>	10f. Zip Code	9		10g. Citizen o	of What Count	try?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dien Evaning roution position	ral	1741 WENTWORT	TH AVENUE			21234			.S.A.	
10	ter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) \(\text{Yes} \)		13. Was Decedent of If Yes, specify C	of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	D- 14. R B	lace - Americ lack, White, e	
036	ours af	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 🕅 N	lo Specify:		Spec	cify: W	HITE
21215-0036	"natu	Completed by Funeral Director	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a	. Decedent's Usual Oc (Give kind of work do	ne durina most of w	rorking	16b. Kind of	Business/Ind	lustry
212	e filed within al Hygiene. I other than "	omp	Elementary/Secondary (0-12)	College (1-4or 5	i+)	'life. DO NOT use ret	,		WING.	ARD &	COMPANY
nd	be filed Ital Hyg Id othe event,	Be C	17. Father's Name (First, Middle, Las CHARLES		EREIHN		18. Mother's N	ame (First, Middle		_{ame)} EIGER	1
Maryland	ould by Ment narked natic e	ဥ									
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, ir a Martical Example in the modified and the control of the control in the modified and its model.		19a. Informant's Name/Relationship JUDI BENTZ-AN		1	o. Mailing Address (Stre 741 WENTV			er, City or Tow TLLE ,		21234
Baltimore,	es 1 and 2 of Health item 27 r other tr		20a. Method of Disposition			of Disposition (Name of ery, crematory or other p		Date		n - City or To	wn, State
ii ii	Eagle Trant: It Tant: It jury o		1 ☐ Burial ② ☐ C remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec.		METRO	CREMATOR	RY 7-2	21-2008			LE, MD
Ball	permit. Pages 1 Department of I Important; If ite any injury or of		21. Signature of Funeral Service Lice	ensee		22. Name and Ad		0.00	SEDALE, EDALE,		RAL HOME 21237
			23a. Part 1. Enter the disease, or cor	nplications that caused	the death. Do					110	Approximate Interval Between
سائمهم	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition			11 Huse	TENCCION	1			Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as	a consequence	y Hyper;	12101010				1-07-11-0
	Examine	er	Sequentially list conditions,		HUSET a cr sequence					- 10	YEARS
2,	outed Id ansit	Examiner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,-				1/2	ño.
0,	cate be executed physician and the burial-transit	Exc	resulting in death) Last	Due to (or as	a consequence	of):					
38760,		dical		d						!	
Box (leath certifi attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		مالة. المالية			23d. [Date of delive	ery
В	e deat the attr	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a	2 ☐ Fetal deatl t time of death	n 3 ☐ Ectopic pregna 5 ☐ Other (specify,				Month	Day Year
P.0.	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Phy	9 ☐ Unknown Part II. Other significant conditions	contributing to death b	ut not resulting i	n the underlying cause	given in Part I.	23e. Did	tobacco use co	ontribute to th	e cause of death?
rds,	quires n sign ald be	d by	ATRIAL FIBRILL					1,25	Yes 2 □ No	3 ☐ Prob	ably 4 ☐ Unknown
eco	e law requir has been s le 2 should	plete						24a. Was		b. Were autor	osy findings available mpletion of cause of
<u> </u>	The cate h	Completed						- auto perfo 1 □ Yes	ormed?	death?	
Division of Vital Record	ysician; The is certificate h director, page	Be	25. Was case referred to medical examiner?	Hospital:			74b	eath (Check only		-	1/.
o	ding Phys h. After this funeral dir	Certification: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b.	Time of 28c. Ir	4 ⊔ Nursing		idence 6 💆 C how injury occ		HOSPICE
sior	endin eath. or: Aft he fun	atio	1 Natural 5 Pending 2 Accident investigation		y, rear)		/ork? □Yes 2 □No				
<u>×</u>	or Atteno after death Director: I in by the	rtific	3 ☐ Sulcide 6 ☐ Could not to determined		ury - At home, fa c. <i>(Specify)</i>	arm, street, factory, offic	e	28f. Location (City or To	Street and Nur wn, State)	mber or Rura	l Route Number,
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying P	hysician: To the best	of my knowledg	e, death occurred at the	e time, date and pla	ace, and due to the	cause(s) and	manner as s	tated.
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	(Check only 2 Medical Exa	miner: On the basis o and manner sta	f examination a	nd/or investigation, in m	y opinion, death oc	ccurred at the time	, date and plac	e, and due to	the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	000	10		ense number	ps.	29d. Date sign		
	. 0		30. Name and address of person who	completed sauce of d	eath (Itam 20-1		64395	2	July	18,2	VOS
-	10		DANIEUE DOBER	•		N CHARLE	5 57, 80	UTE 209	BALI	IMME	MO21204
	Sta		31. Date filed (Month, Day, Year)	32 Registra	ar's Signature						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 **Physician** 10:05 A M July 18, Augustus C. Aquino /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Hospice Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Oct. 7, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 1930 New York 101-22-4668 77 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Chambersburg Pennsylvania Franklin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 128 Lantern Lane 17201 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ⊠Yes 2 No 1950− If Yes, Give Year or Dates: 1953 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any injury or other traumatic event, the Mode once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physician Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Aquino Pasqualina Sorge 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Basswood Court, Rockville, Maryland Celeste Aquino/Daughter 15321 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 23, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Funeral Home, Rockville, Inc. Avenue, Rockville, Maryland 20850 Robert A. Pumphrey Funeral 300 W. Montgomery Avenue, Hillian M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (classes or night) that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of): $\int d\mu S/\mu S$ A $d\mu N O$ Division of Vital Records, P.O. Box 68760, Physician/Medical been signed by the attending p should be detached for use as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 21 No certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician; 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: $4\square$ Nursing Home $5\square$ Residence $6\cancel{X}$ Other (Specify) Hospice1∐Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🛚 Natural 5 Pending investigation the Funeral Director: After and the full of the full o 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerevieve Wroblewski, 6001 Muncaster Mill Road, Rockville, Maryland 20855 M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 2008 Bonsall **Physician** JULY 1:30 PM Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Center Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours Min 1 **№** M 2 🗆 F 6-24-1947 Ohio Director 61 276-42-3173 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show s 23a or 28a-f show 1 XYes 2 No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21210 Unit 3D 230 Stony Run Lane U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) If of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examine 1.1 Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married White Maryland 21215-0036 1 ☐ Yes 2X No Specify: ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ride & Drive Elementary/Secondary (0-12) College (1-4or 5+) Journalist 5+ Features L.L. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bonsall Gilcrest Mabel Alice ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Kevin Scott Lowery - Partner 230 Stony Run Lane Unit 3D Balto. Md. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-19-08 Baltimore, Md permit. Page Department of Important; If any Injury or once. Greenmount Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Joseph N. Zannino Jr
263 S. Conkling ST. Funeral Home 21. Signature Funeral Service Licensee Jг. Balto. Md. 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause Final disease or condition resulting in death)

SEFSIS

Die to (or see a second condition) Approximate Interval Between Onset and Death Physician /Medical Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate caus. English Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown VASCULAR Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗆 No 1 □ Yes After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation s a er death. I Director. Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide o 24 hours at e Funerat Di etely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hospi within 24 hou To the Funer completely fill Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08 D37254 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State Registrar

BOON POH LIM M. D. 7601 OSLER DRIVE 32. Registrar's Signature

TOWSON. MD 21204

08-05449 Jerome Brown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ome Brown	1-	State of Maryland / Department of Health and Mental Physics For State Certificate of Death	Reg. N	2 (J08 23 <u>3</u> 0
Physicia	R	egistrar 2. D	ate of Death		3. Time of Death
►" ¬I Examir		Jerome Brown	ıly 15, <u>2008</u>	4c. County of De	2122 hrs
	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Labrac Honkins Honkins Honkins Honkins Honkins Honkins Honkins Honkins Honkins Honkins Honkins Honkins Honkins Honkins		N/Z	
		Johns Hopkins Hospital	Date of Birth(M	M/DD/YYYY) 9.	Birthplace (State or
Funeral Director	1	Months Days Hours Min.	1/16/9	I E or	reign Country) MD
Director	Ļ	Jsual Residence of Decedent			
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 No
<u>*</u>	٦	MD N/A Baltimore		O'E of Milest C	
Aaryla 28a-f	Director	10e. Street and Number		Citizen of What C	ountry?
with the Maryland ns 23a or 28a-f show be notified at once.		4708 Greenhill Avenue 21206 11. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific		USA 14. Race - Ar	merican Indian, Black,
tems 2		1 Married 2 Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rica	an, etc.)	White, etc	ican
ter dea		X Widowed 4 Divorced If Yes 2 X No 1 Yes 2 Y No specify:		SpecifyAme	erican
urs afi	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)		b. Kind of Busine	:ss/Industry
5 72 ho nn "na cal Ex	ete	Elementary/Secondary (0-12) College (1-4 or 5+) 10 Order Filler		Tailer	Rental
within jene.	Completed	17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Last)	rst, Middle, Mai	den Surname)	
21215-0036 and be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be C	Harold M. Brown Ingrid I	Robins	on	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene T is marked other than "matural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			
MD d 2 sho Ith and n 27 is aumati		Ingrid Robinson/Mother 1063 W. Lexington State Method of Disposition (Name of cemetery, D	St.,Ba	1t., MD	ty or Town, State
		20a. Method of Disposition		Baltimo	
Page ment c		Mc. Calmel Cem.	· •		
Baltimore, permit. Pages I ar Department of He Important: If ite	8 0	21. Signature of Full Service Up 155. 22. Name and Address of Facility Hari 5126 Belair Rd, Ba	P. CI altM	ose F. D 2120	SVS,P.A 6-5105
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	espiratory arrest	, shock, or heart	Approximate Interval Between Onset and
Ledical	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries			Death
kaminer		or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	턡	cause. Enter Underlying Cause			
ust g'hu	Examiner	events resulting in death) Last Due to (or as a consequence of):			
execution and and al-trau		UNPENDED AMENDED			
60, ate be exe hysician a	sician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	
687 ertifica ding p e as th	an/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnance 4 Pregnant at time of death 5 Other (Specify)	су	Month	Day Year
Box 6876 The death certificate the attending phy ned for use as the last	/sic	1 Yes 2 No 9 Unknown 9 Unknown			
that the d	, Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ute to the cause of death? Probably 4 Unknown
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rds v requi	ompleted		autops perforr	y pri	ior to completion of cause of eath?
Che lav	E		1 ✓ Yes 2		✓ Yes 2 No
al R ian: 1 certific	BeC	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other4 Nursing		Residence 6	Other:
Division of Vital Records, P.O. Box 68760, To the Inospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	E	1 V Yes 2 No Time of Injury 2 Work? 12	28d. Describe h	ow injury occurre	d
n of ding l h. Afte e funer	<u>ë</u>	1 Natural 5 Pending Jul 15, 2008 1526 hrs 1 Yes 2 ✔ No	oicyclist in co	ollision with a	iuto
Vision or Attendather death Director:	icat	Zoe, Flace of Highly - At Home, family at the start of th	28f. Location (S or Town, St		r or Rural Route Number, City
Div ospital or hours aft uneral Di	Certification:	determined (Specify) Local Street	2000 Belair Ro	oad, Baltimore,	
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and of (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	due to the cause the time, date a	e(s) and manner a and place, and du	as stated. ue to the cause(s)
To the Hos within 24 h To the Fur completely	Medical	and mariner stated.		29d. Date signe	ed (Month, Day, Year)
	Σ	29b. Signature and title of certainer		July 16, 200	08
		30. Name and address of person who completed cause of death (Item 23a)			
3		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
	 State	Registrar's Signature			
Regi					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day Month **Physician** 2008 2:57 AM July 18 Helen Gertrude Brady /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1813 Old Eastern Avenue Apt 232 Baltimore Essex If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 12/22/1920 87 Maryland Director 220-05-0404 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, 13, Wodical Examination ust by a solution at 1 ☐ Yes 2 No Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1813 Old Eastern Avenue Apt 232 21221 S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2X No Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Aero Space 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B ಲ Thomas Francis Brady Catherine Anna Kopp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21221 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Milford Lynwood Hall (Husband) 1813 Old Eastern Avenue Apt 232 Essex, Maryland altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licenses PA Essex, Maryland 21221 Lichard da 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardon **Physician** Acute /Medical Due to (or as a consequence of) Examiner Doyto (or as a consequence of): Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 💆 No 4 Pregnant at time of death 5 Other (specify) Records, P.O. e has been signed by the ge 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe he 1 ☐ Yes 2 ZXNo certificate 1 ☐ Yes 2 ☐ No o Division of Vital Hospital or Attending Physiclan: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0039297 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) 5 Rd. Bultimore IK. KO 2314 Michael 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Year

3. Time of Death

10d. Inside City Limits

Onset and Death

Day

2 | No

Year

1 Zes 2 No

for State Registrar 1. Decedent's Name (First, Middle, Last) BELL Month **Physician** CrURIE 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner If Under 24 Hrs Hours Min. If Under 1 Year Date of Birth **Funeral** 243400009 Months Davs Director Usual Residence of Decedent hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Evantier must be notified at Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 □ Yes 2 🔼 Specify. 3 Nidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. College (1-4or 5+) 17. Father's Name (First, Middle, Last) Maryland 18 Mother's Name (First, Middle, Maiden Surname) Be ပ္ 19a. Informant's Name/Relationship (Type. Print) Baltimore, 20a. Method of Disposition Important: If It any Injury or conce. 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyld shock, or heart failure. List only one cause on each line. g, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) STOMACH CANCER Physician /Medical Due to (or as a consequence of): Examiner 57 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Lue to (or as a consequence of) -transit death certificate be executed Due to (or as a consequence of): burialphysician Be Completed by Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy 5 Other (specify) Ö 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 I Unknown þ ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe HOLANGEITT 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 autopsy 2 No 1 □Yes 1 ☐Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2. No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide (Check only To the h

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d Date signed (Month, Day, Year) 076 Name and address of person who completed cause of death (Item 23a) (Type, Print) & ELASSON WOLLD Mile duly nhie Rd, Bourd, Ma 2123 State Registrar DHMH 17 Rev 1/2001 ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 23308 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** TAMARA 17,2008 BOYKO 12:46pM JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1200 FALLSTON ROAD FALLSTON HARFORD 8. Date of Birth (Month, Day, Year) OCT. 12,1932 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 **②** F 216-32-2980 75 Yrs Director UKRAINE Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturei", or items 23a or 28a-f ehow other treumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director MD HARFORD FALLSTON the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 FALLSTON ROAD 21047 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 20 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 BEAUTICIAN BEAUTY SALON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be marked o MYKOLA KORSCH 2 CHRYSTYNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health ANNA JENNINGS/ DAUGHTER 1421 E. MACPHAIL ROAD, BELAIR, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: if eny injury or once. ST. ANDREWS CEMETERY 7/21/08 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee LTLT WEELEN INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tu condiousan D. + **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): physician and s the burial-transit certificate be executed Due to (or as a consequence of) Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records. 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Yes 2/2 No 1 Yes of Vital : After this certification afuneral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide To the Hospitai 1 Configured Physician: To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and manner and manner and manner. 29a Certifier Medical and manner stated. 29b. Signature and title of ceptifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNETH WILLIAMS, M.D. 2801 FOSTER AVENUE BALTIMORE MD. 21224 32. Segistrar's Signature 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 23309 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Jul 12, 2008 4:42 p Physician Margaret T. Brunson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Windsor Mill 7738 Big Bucks Drive If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Min. Months Hours 1 ☐ M 2 🛣 F May 8, 1935 73 216-30-0615 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location death with the Maryland 10b. County show 1 Yes 2 No Windsor Mill Baltimore ns 23a or 28a-f sh must be notified Director Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21244 7738 Big Bucks Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If frem 27 is marked other the any injury or other traumers. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 ☐ MNo Specify Specify: <u>}</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hospital Elementary/Secondary (0-12) College (1-4or 5+) Janitorial Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Richardson Alexander Richardson ပို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7738 Big Bucks Drive Windsor Mill, Maryland 21244 Kevin Brunson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 MBurial 2 □ Cremation 3 □ Removal from State 07/18/08 Baltimore, Md. Woodlawn Cemetery & Chapel 4 □ Donation 5 □ Other (Specify) 21. Signature Ineral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Marin Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANCREATIC /Medical Due to (or as a consequence of): 8 MONTHS Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 Mo 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2**X** No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 1 ☐ Yes 2×2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 25 No Certification: To this funeral (27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu investigation 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

N. EVTAN ST BALTIMORE MD4201

821

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year!

KRI3H NAN

- ANANDA

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician 10/am leman 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign South Cavolina Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Months Hours 1 ☐ M 2 🗗 F 26 3682 Yrs Carolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 Yes 2 No Director mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify δ 3 ₩idowed 4 Divorced Year or Dates Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use refired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) . Mother's Name (First, Middle, Maiden Surname, Be 19b. Mailing Address (Street and Number or 19a. Informant's Name/Relationship (Type. Print) Rural Route Number, City of O eman 20c. Location - Oity or Town, State 299 Frederick Rd 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Decremation 3 Removal from State -19-08 Crematory metro 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 200 €.1 Excuption ST. Mezz Space 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Caudra Tours disease or condition resulting in death) /Medical Due to wr as a consequence of) Examiner Sequentially list conditions, if dry, leading to infine list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tyes 2 No 3 Probably 4 Whiknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1∐ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 PER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours a

To the Funeral I

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

29b. Signatur

(Check only one)

30, Name and address of person

31. Date filed (Month, Day,

crugg

and manner stated.

who completed cause of death (Item 23a) (Type, Print) 6000

Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7. 20 AM JULY HDRIANA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE WASHINGTON MEDICALI ANNE ARUNDEZ BURNIE (JLEN ENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
_____ 8. Date of Birth (Month, Day, Year) 10–18–1923 Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral 1□M 2×F Months Days Min 219-40-9885 84 Yrs Director Italy Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Modical Experiment mast be notified at Director 1 ☐ Yes 2 ☑ No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1060 7th Street 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: white Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Owner Home maker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Aurelio Paolini Isola Banini မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Mr. James Ebler / son 1060 7th St., Glen Burnie, MD 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State jo July 24, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Balto Nat'l Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008Baltimore City, Maryland 22. Name and Address of Facility Kirkley Ruddick Funeral Home PA 21. Signature of NU 421 Crain Hwyse, Glen Burnie MD 21061 M01364 Approximate Interval Between Deet and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CPITOTEN disease or condition resulting in death) /Medical Due o (or a a consequence of): Examiner sit any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed on Lective attending physician and for use as the hurial-tran resulting in death) Last Due to (or as a sonsequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the a P. 0. 9 Unknown reate has been signed by ; , page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 1 inpatient After this 27. Many er of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number The 30. Name and addless of person who completed lause of death (Item 23a) (Type, Print) 0 32. Registrar's Signatur 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Thelma Clark 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arunder BUr Elen 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Yea 3/24/1946 Birthplace (State or Foreign 5. Social Security Number 1 M 2√2 F Months Days Hours Min. 62 214-46-1351 MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 ∐Yes 2**X** No Anne Arundel Severn MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 USA 7959 Telegraph Rd. Lot 18 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 Never Married 2 X Married white 1 ∐Yes 2. XINo Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Atlas Van Elementary/Secondary (0-12) College (1-4or 5+) Packing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thomas Wood Thelma Hardesty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie MD 21061 1213 Oakwood Rd Thelma Clark/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cemetery 7/22/2008 Crownsville, MD MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kirkley Ruddick Funeral Home PA M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list condit

Physician /Medical Examiner

Physician

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/Medical

Director

Funeral

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Completed

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physician and s the burtal-trans attending p for use as t been signed by the should be detached page this

law requires that the death certificate be executed

To the Hospital or Attending Physician: The

Division of Vital Records, P.O. Box 68760,

thours after death.

uneral Director: A

ely filled in by the fu within 24 hours a To the Funeral I completely

dical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 🗆 Ectopic		2	3d. Date of de Month	livery Day	Year
Completed by Ph	Part II. Other significant conditions or	ontributing to death but not resulting The Co	g in the underlying AML	cause given in Part I.	23e. Did tobacco us 1 ☐ Yes 2 ☐ 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No		robably 4 utopsy findir completion	☑ Unknown
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 反 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/	Outpatient 3 🗆 [Othor	ath (Check only one) Home 5 ☐ Residence 6	☐Other (Spe	ecify)	
Certification: To	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	o. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury			
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Specify)			28f. Location (Street and City or Town, State)			Vumber,
g		ysician: To the best of my knowled						se(s)

29d. Date signed (Month, Day, Year)

State Registrar

one

31. Date filed (Month, Day,

29b. Signatu

and manner stated.

32. egistrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 11:40 AM 2008 Cordell Craighead July 20. Barry /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 1832 Kittyhawk Road ESSEX
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Essex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Vear Days Months Hours 1 XM 2 □ F Yrs 214 38 2306 64 Nov.15,1943 **Director** Tennessee Usual Residence of Decedent with the Maryland 10d Inside City Limits 10c. City, Town or Location 10h. County 10a State 28a-f show ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, Inc. IV silc... Examiner must be notified at 1 ☐ Yes 2 🕍 No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number S. A. 1832 Kittyhawk Road 21221 U. Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. e filed within 72 hours after cal Hygiene. 1 Types 2 □ No
If Yes, Give Year or Dates: 1961/64 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No Specify: Specify: 2 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Signal Construction Mechanic Baltimore County Gov. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental Fitem 27 Is marked ot Be Annie Susan Hewitt Horace Donoho Craighead ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1007 Rosemont Drive Joppa, Maryland 21085 Patsy Wolfe (Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran Cemetery Garrison Forest, MD 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. CARDIOVASCULAR Immediate Cause (Final ATHEROSciezona **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a 1 □ Yes 2 □ No. 9 Unknown 9 Unknown ď. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ⋧ ALCINOMA 1 ☐ Yes 2 ☐ No → Probably 4 ☐ Unknown been si should l Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □Yes 2 XNo has page 2 s certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

leral Director: A
filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours a 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 200 30. Name and address of perein who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

^{Year)} 2008

32. Registrar's Signature

mo

217-37 Liya Pfeffer, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 19,2008 July COMMODORE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI 140SpiTA1 0+ BAltimore BAltimore (ily 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F Months Hours Director 214-24-5548 01/17/1919 SC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1XXYes 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 607 CLAYMONT AVENUE 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify þ Specify: 3 ₩ Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) BCPS CAFETERIA **DIETARY ASSISTANT** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM McCLURE NANNY WRIGHT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, NAOMI McGEE/GOD-DAUGHTER 1818 E. NORTH AVE. BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Purial 2 ☐ Cremation 3 ☐ Removal from State 7-26-08 BALTIMORE, MARYLAND DRUID RIDGE CEMETERY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Heart **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Ś signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★ No 24a. Was an ate has b autopsy performed? certificate director 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours a er deat To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) PhysiciAN ed cause of death (Item 23a) (Type, Print) 30. Name and address of perso BURKE, TR, MP SINAT HOSPITAL OF BALTIMORE EDERIU 3 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 1 2008 Registrar

			For State	State of Maryland	/ Depa		leaith and M		2000	23315
ě.	Physici /Medic		1. Decedent's Name (First, Middle, Last)	aviengto				2. Date of Death Month	Day /t 2008	3. Time of Death 6-27A M
	Examin Funeral Director		4a. Facility Name (If not institution, give si G ood SAM MAL TO 5. Social Security Number 6. Sex $219-28-0612$		t birthday) Yrs.	4b. City, Town, or BH If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death No. 1 9. Birth County 9. Birth County 9. Birth County 9. Birth	place (State or Foreign
	ne Maryland 8e-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County Mill , N/A	10c. City, T		nore 10f. Zip Code		100	Citizen of What Cou	10d. Inside City Limits Yes 2 □ No
	death with the 23a or 2	Funeral Dire	5 / 22 PlAin Field 11. Marital Status	2. Was Decedent Ever in U.S.	13. V	2/2	OC lispanic Origin? (Span, Mexican, Puerto		14. Race - Ameri Black, White,	A can Indian,
9800	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23e or 28e-f ehow Ite Madical Evanii etrasi be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify: B	ik
Maryland 21215-0036	filed within 72 Hygiene. sther then "net ent, in e Medic	Completed	(Specify only highest grade	completed) College (1-4or 5+) MONC	(Give lite. E	kind of work done OO NOT use retired			touse u	
ryland	2 should be filed and Mental Hygis le marked other eumatic event, III.	To Be (17. Father's Name (First, Middle, Last) UN KNOW 1 19a. Informant's Name/Relationship (Typ.	ne Print)	19b. Mailin	a Address (Street	Ann c	First, Middle, Mai Mail Mail Mail Mail Mail Mail Mail Mail		ip Co d 1306
	es 1 and 2 shoof Health and of Health and fitem 27 le m r other treum		CCC i /i A Mi// 20a. Mathod of Disposition 12 Burial 2 □ Cremation 3 □ Re	lek 20b. Plac	5/20 ce of Dispos	01	HAVE!	At. Filest	Flor Ban c. Location - City or T	D.M.D.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturat", or Iteme 23a or 28e-f show any injury or other treumatic event. If a Medical Examinist matter Difflied at Once.		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	K		Mem. Pla. Name and Addre		119,2007 F	ANDALISTO . 11	5001 MD.
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. e cause in each line. Due to (or as a consequer	e A	er the mode of dying	ng, such as cardiac			Approximate Interval Between Onset and Death
8760,	eath certificate be executed attending physicien and for use as the burial-transit	dical Examiner	Sequentially list conditions, it any, leauning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent						
.O. Box 68	The law requires that the death certifical the has been signed by the attending phropage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	eath 3	Ectopic pregnance Other (specify)	у		23d. Date of deli- Month	very Day Year
S, D	n requires that the de been signed by the should be detached		Part II. Other significant conditions con	tributing to death but not resulti	ing in the u	nderlying cause giv	ven in Part I.		cco use contribute to	
Vital Record		Completed						24a. Was an autopsy performe 1 Yes 2	prior to c	topsy findings available completion of cause of
of	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Natural 5 Pending investigation		R/Outpatier 8b. Time of Injury	28c. Inju	ner: 4 \[Nursing Horsing h (Check only one) ome 5 Resident 28d. Describe how	ce 6 Other (Specialist)	ify)	
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	the Hospit tin 24 hour the Funere	edical	(Check only 2 Medical Examination)	sician: To the best of my knowle ner: On the basis of examinatio and manner stated.	edge, deatl en and/or in	vestigation, in my	opinion, death occur	red at the time, dat	se(s) and manner as and place, and due	to the cause(s)
	with To	Σ	29b. Signature and title of certifier	· Tonpen	aer	29c. Licen:	30661	J	eely 14"	t 2008
			30. Name and address of person who co	mpleted cause seeth (Item) 2		Balli	mille.	rd-	21239	7.
	St Regist	ate rar	1111 2 1 201	IR America A	1	esto 1				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 8/9 M SABELLE COLF 0 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BQ 1-timore Bayview Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2√2F 214-56-6234 June 25, 1951 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Example. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County MD N/A BALTIMORE 1 X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? #810 3700 GREENSPRING AVE. 21211 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK ò 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A BAR MAID BAR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George A. Cole Corrine Dukes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette A. Brunson -Daughter 1342 N. Stockton St. Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4.☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 7/21/08 Baltimore, MD e of Funeral Service Licen ee 22. Name and Address of Facility March Funeral Home West, Inc. 23a. Patri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD 21215 shock, or head value. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): peritonitis Examiner Bacterial sif any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Allohol liver The law requires that the death certificate be execute attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ØNo Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 2 Mo or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
neral Director; A
filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours aff 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R ES. 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern Avenue, Baltimore, MD, 21224 Mobyla 4940 nda 32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

08-05514 Michael A Cook Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Chael A Cook		State of Maryland / 1-For State Registrar	Certificate			_{a. No.} 200	8 2331
Physici	an/	Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death
edical Exami	iner	Michael Ant 4a. Facility Name (if not institution, give street and number)	hony	Cook 4b. City, Town, or Location o	Month July 18, 20	08 4c. County of Death	1114 hrs
		Baltimore Washington Medical Center		Glen Burnie	·	Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Unde	r 24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birth	
Director		230-15-8726 1XM 2F	47 Y	rs. Months Days Hours	Min. 06 05		ntry) VA
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation			10d. Inside City Limits
<u> </u>	_	MD Anne Arundel		adena			1 Yes 2 X No
Maryland 28a-f show d at once	ecto	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Coun	ry?
ith the Maryland 23a or 28a-f sho	i Dir	8325 Beechwood Park Ro	ad	2112	2	U.S.A.	
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Nould be filed within 72 hours after death with the Maryland tem 27 is marked of ther than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at one	Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces?	If	Vas Decedent of Hispanic Orig f Yes, specify Cuban, Mexican,		14. Race - Americ White, etc.	an Indian, Black,
imore, MD 21215-0036 Pages I and 2 should be filled within 72 hours after death winner of Health and Montal Hygiene. Anni: If item 27 is marked other than "natural", or items or other tranmatic event, the Medical Examiner must be.		3 Widowed 4 Divorced of Pares:	No 1	Yes 2X No specify:		Specify: B	lack
hours a	ed by	15. Decedent's Education (Specify only highest grade com	during	ent's Usual Occupation (Give I		16b. Kind of Business/Ir Gospel Mi	dustry
36 iin 72 l han "; dical F	Completed	Elementary/Secondary (0-12) College (1-4 or 5	(+)	ospel Singe		Ministry	usic
5-00 ed with lygiene other 1 he Me	Com	17. Father's Name (First, Middle, Last)			's Name (First, Middle, M		
21215-0036 21215-0036 buld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	Thomas J. Cook		Ida	May Davi	S	
MD 2 nd 2 should thy and M m 27 is m	7	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and Num	ber or Rural Route Num	ber, City or Town, State,	Zip Code) 21122
e, M and 2 Health item 2		Valerie Cook-Wife 20a. Method of Disposition	20b. Place of Disp	Beachwood osition (Name of cemetery,	Date Date	20c. Location - City or	
MOre Pages 1 nent of H ant: If it		1 XBurial 2 Cremation 3 Removal from Sta 4 Donation 5 Other Specify:			7/25/08	Glen Bur	nie, Md
Baltimore, permit. Pages I ar Department of Hec Important: If ite		21. Signatur of Fineral Service Licensee	22 M	Name and Address of Facility	st		
		23a. Part I. Enter the disease, or complications that caused	j 4	300 Wabash	Ave, Balt	imore, Md	21215 Approximate Interval
Physician 'Medical	į.	failure. List only one cause on each line.		rdiovascular Disease	ardiac or respiratory arre	st, shock, or treat	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atl		diovasculai Disease			
	Ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	quence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated					
uted Id ransit		events resulting in death) Last Due to (or as a conse	quence of):				
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED					
760, ficate be g physic s the bun		IF FEMALE: 23c. If yes, outcom 23b. Was decedent pregnant in the		Established 2 Establish	prognonou	23d. Date of delivery	Your Your
Box 687 e death certific the attending p ed for use as th	Physician/	past 12 months?	ime of death	Fetal death 3 Ectopic Other (Specify)	pregnancy	Month D	ay Year
Bo he dear	hys	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death	hud not appulate a to the	e underlying cause given in Pa	Lago Did to	bacco use contribute to t	he source of death?
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eco he law ate has	dmc	-			autops perform	med? death?	
al R ian: T certifica ctor, pa	Be C	25. Was case referred to medical examiner?		26.Place of Death			
Yit Physic r this o	To E	1 Yes 2 No		ent 3 DOA Other		Residence 6 Other	
rding I	ion:	27. Manner of Death 28a. Date of Injur (Month, Day,Ye	ry 28b. Time o	of Injury 28c. Injury at Work		low injury occurred	
IVISION I or Attent after death Director:	ficat	2 Accident Investigation	ury - At home, farm, st	reet, factory, office building, et	c. 28f. Location (S	treet and Number or Ru	ral Route Number, City
Divipital o	Certification:	4 Homicide determined (Specify)			or Town, St	tate)	1
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.		29a. Certifier (Check only one) Certifying Physician: To the best of my Medical Examiner: On the basis of exam	-				
To t with To tl	Medical	29b. Signature and title of certifier.		29c. License number	at any anno, uglo (29d. Date signed (Mor	
_		()/ antula 11110		O.C.M.E.		July 19, 2008	
H		30. Name and address of person who completed cause of de				<u> </u>	
\		Laron Locke MD. Assistant Medical Exa	100	nn Street, Baltimore, M	D 21201	· · · · · · · · · · · · · · · · · · ·	
Si Reais	tate	31. Date filed (Month, Day Year) 2008 Registrar	s signature	2450 1			

DHMH 17 Rev 1/2001 OCME 2006

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - For State Registrar 23318 Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** CHMILEWSK 5:30 PM JUL 2008 /Medical 4a. Facility Name (If not institution. give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltruce ode 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 □ F Months Days Hours Min. 217-26-2567 Yrs. Sept 5, Maryland Director 76 1931 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1♥ Yes 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2131 Lodge Forest Drive 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 152–56 If Yes, Give Year or Dates: 149–52 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed by Specify: white 3 Widowed 4 Divorced 149-52 other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **12** 0 mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Chmilewski Stella Korytkowski ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) May Chmilewski/spouse 2131 Lodge Forest Drive Baltimore, MD 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Anthony 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Pleasant Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a (accer 6 ruch disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequency Examiner executed as the burial-transi attending physician and Due to (or as a consequence of): Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a Id be detached for 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 1 Yes after death.

Director: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1-Inpatient Certification: To 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 ☐ Accident 6 Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, address of p rson Baltinere MD 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

ÖRIGINAL

DHMH 17 Rev 1/2001

08-05441 Harold Cox

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 23319

		1- For State Registrar		•	Ċerti	ficate of	f Death	7		,,	Red	a. No.		
Physicia		Decedent's Name (First, Mid	dle,Last)								Date of Death	1		3. Time of Death
"nal Exami	ner	Harold Cox								ل	uly 15, 20	08 Yea	ir	1518 hrs
		4a. Facility Name (if not institut	ion, give stree	t and number)			4b. City, To		ocation of	Death		4c. County of	of Death	
		1012 Hewitt Way					Baltim	ore						
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. las	t birthday)	If Unde		If Under		. Date of Birtl	(MM/DD/YYYY	9. Birt	thplace (State or
Director		214-56-8857	1 X M	2F	56	Yrs	Months 5.	Days	Hours	Min.	July 15, 2008 4c. County of Death			
		Usual Residence of Decedent												
v any		10a. State 10b. Count	4		10c. City, To	own or Locat	ion					·		
and show	님	MD			Ва	1timor	e							1 X Yes 2 No
faryls 28a-f	Director	10e. Street and Number					10f. Zip	Code			10	g. Citizen of Wi	nat Cour	ntry?
ith the Maryland 23a or 28a-f show any notified at once.		1012 Hewitt	Way					2120)5			US	A	
with ms 23 be no	Funeral	11. Marital Status		Vas Decedent										can Indian, Black,
death or Ite	Ĕ		1 X	Armed Forces? Yes 2	No	IT Y	es, specify	y Cuban, I	Mexican, F	Puerto Ric	an, etc.)	White	e, etc.	
after 'al",	by		or Da	Give Year 16		1	Yes 2	X No	specify:			Specify:	whi	te
hours natur Sxam	ba	15. Decedent's Education (Sp				6a. Deceder	nt's Usual C					16b. Kind of Bu	ısiness/İ	ndustry
36 n 72 ical E	ompleted	Elementary/Secondary (0-12	() C	ollege (1-4 or	5+)			-		00 100100)				
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Shou and N 7 is n	٩	Margaret Hilp		,	71	i								, ZIP Code)
and 2 ealth tem 2 traum		20a. Method of Disposition	ert/mo	ther	20b. Pla	ace of Dispos								Town, State
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nr. If Heem 27 is marked other than "natural", other traumatic event, the Medical Examiner.		1 Burial 2 Cremati	on 3 Re	moval from Sta		ematory or ot			,,				,	
ti. Pag tmeni rtant		4 X Donation 5 Other				-						J. NO. J. L		
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		2 Signature of Function Vio	y LivinseeP	Leasant	-				-			. Balti	imor	e Street
	-	23a Part I Enter the disease	or complication		the death F	B not enter t	altim	ore,	MD	2120	1	et shock or he	art	Approximate Interval
Physician Medical		failure. List only one caus	e on each line	9.						ruiac or res	spiratory arre	St, SHOCK, OF HE	ait	Between Onset and
≟xaminer		Immediate Cause (Final diseas or condition resulting in death)		rtensive A			iovascul	lar Dise	ase					Death
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	亘	Sequentially list conditions, if any, leading to immediate		(or as a cons	equence of):									
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ited d ansit		events resulting in death) Las	d Due to	(UI as a CUIIs	equence on).									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	/Medical	UNPENDED	AME	ENDED							-			
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687 ertific ding p		23b. Was decedent pregnant in past 12 months?		Live birth	_	2 F6	etal death	3	Ectopic	pregnancy	1			
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he de freed f	ξ	Part II. Other significant cond	9	Unknown					i D		O2a Did to	h	rib.uta ta	the serves of death?
tal Records, P.O. Box 68: cian: The law requires that the death certifi certificate has been signed by the attending ector, page 2 should be detached for use as it	þ	art ii. Other significant conc	inions contr	ibuting to deat	n but not res	uiting in the	underlying	cause giv	ren in Fan	l I.				
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of ing Pt After funeral		27. Manner of Death 1 ✓ Natural 5	2	Ba. Date of Inju (Month, Day,)	ıry 2 (ear)	28b. Time of	Injury 2		at Work?	l l	d. Describe h	low injury occur	red	
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Hospital 24 hours a Funeral tely filled	S	4 Homicide	termined	(Specify)						ţ.				
Division of Vital Rec To the Hospiral or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page														
To the within 2 To the complet	Medical		and r	nanner stated.	mination and	or investiga				urred at th	e time, date a			
	2	29b. Signature and title of certi	ner -				29c	. License		OCME				onth, Day, Year)
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		30. Name and address of person				,	4445	C1	-6 D-11	linn	MD 04004			
	لي	Theodore M. King, J		Assistant M			111 Pe	enn Stre	et, Balt	umore, i	VID 21201			
St Regis	tate	31. Date filed (Month, Day, Yea	2008	32. egistra	rs Signatur	Col	ale s							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 545 AM Joan Clara D'Amico 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FRANKLIN SQUARE HOSPITAL CENTER Rosedale Baltimore 8. Date of Birth (Month, Day, Year) 04/22/1930 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Min. Months Davs Hours 1 □ M 2 🖫 F Maryland Director 213-26-1869 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinat must be notified at 1 ☐ Yes 2 No Maryland Baltimore Middle River Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 U.S.A. 1201 Middleway Road, #3C by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mae Gordon Charles Wetz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2510 North Charles Street, Baltimore, Maryland 21218 Carole Agelopas (Daughter) altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 07/19/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of activities in Funeral Home, 21 Signature of Fun al Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imm te Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran P.O. Box 68760, 5 Due to (or as a consequence of): attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral in the fun 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar 30. Name and address of person who completed cause of

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DR Kam L

31. Date filed (Month, Day,

9000 FRANKLIN

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eath (Item 23a) (Type, Print)

UNE

32. Registrar's Signature

08-05472 Ce

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

ecil Dunlap	1	State of Maryland / Department of H For State Certificate of De		Hygierie Reg.	201	08 233
Physicia		Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
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Funeral Director		or occidir occurry realiser		10/17/1	L 951 Foreig	ountry) MD
		Usual Residence of Decedent				10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town or Location				1 Y Yes 2 No
Aaryland 28a-f show 1 at once.	힐	MD BALTIMORE 10e. Street and Number 10	Of, Zip Code	10a	Citizen of What Cou	A
e Mar or 28a	Director	Toe. Street and Number			USA	
ath with the Mi tems 23a or 20		433 WHITRIDGE AVENUE 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	21218 ecedent of Hispanic Origin? ((Specify Yes or No-	14. Race - Ame	rican Indian, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If Yes,	specify Cuban, Mexican, Pue	erto Rican, etc.)	White, etc.	
	by F	Widowed 4 XXDivorced If Yes, Give Year 1 Ye	s 2xx No specify:			ACK
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Ore,		1 Burial 2 X Cremation 3 Removal from State crematory or other	place)		n + - m	NADWI AND
tim t. Pag tment tment rtant;		4 Donation 5 Other Specify: METRO CREM Signature of Funeral Service Licensee 22. Nam				E, MARYLAND ONS F.H.,INC
Baltimore, MD 21 permit, Pages I and 2 should Department of Health and Mc Important: If Item 27 is ma hijury or other traumatite	1	C 200 +	1-31 LAURENS			21217
Physician	-	234 Part I. Enter the disease, or complications that caused the death. Do not enter the	mode of dying, such as cardi	ac or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive atherosc)	erotic cardi	ovascular	disease	Death
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Division of Vital Records, P.O. ral or Attending Physician; The law requires that thers after death. To Director; After this certificate has been signed by led in by the funeral director, page 2 should be detach	l by	Ccoaine use		1 Yes	2 No 3 P	robably 4 🗹 Unknown
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Vital Rec tysician; The this certificate I director, page		25. Was case referred to medical	26.Place of Death (Ch	neck only one)		
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ivis lor Au after of Direc	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	factory, office building, etc.	or Town, St		Rural Route Number, On
Dospita hours meral y fille	Ş	4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre	d at the time, date and place	and due to the cause	e(s) and manner as s	tated.
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ON STATE OF THE	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		Mhan Barrell MD	O.C.M.E.		July 17, 2008	
₩ .		30. Name and address of person who completed cause of death (Item 23a)				
		Melissa Brassell, MD Assistant Medical Examiner 111 Pe	nn Street, Baltimore,	MD 21201		
	tate	1111 0 1 2000 664 66 40				
Regis	trar					
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#A265016 DENNIS Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

	1. Decedent's Name (Fi	rst Middle Last)		Cer	tificate	of Deatr	7	2. Date of Dea	Reg. No. 2	000	3. Time of Death
sician edical -	7. Dooden o Hame (17	roi, imagre, Laor		die W	. Denr	nis				Jul 14, 2	008 ^{Year}	3:45 р м
miner	4a. Facility Name (If not					4b. City, Tov	vn, or Location	of Death	nore	4c. Cou	inty of Death	n/A
rai	5. Social Security Numb	er 6. Se		ington Age (In yrs. Ias	st birthday)	If Under 1 Y		er 24 Hrs.	8. Date of Birtl	h Vaarl	9. Birth	nplace (State or Foreign
or	228-05-90 Usual Residence of Dec	25	34 M 2□ F	88	Yrs.	Months D	ays Hours	Min.	(Month, Day May 2	2, 1920	Cot	Virginia
		o. County		10c. City,	Town or Loc	cation						10d. Inside City Limits
Director	Maryland 10e. Street and Number		/a			106 7in On	Baltimor	re		10- 01	26 14/h 21 O	1 MYes 2 No
once. To Be Completed by Funeral Director	1520 West N		e			10f. Zip Co		217		10g. Citizen	U.S	
Funeral	11. Marital Status	-5	12. Was Deceder Armed Force	s?	13. V	Vas Decedent f Yes, specify	t of Hispanic O Cuban, Mexica	rigin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - Amer Black, White	
b	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates		1	□Yes 2□	No Specify	y:		Spe	ecify:	Black
leted	15. (Specify o	Decedent's Edu nly highest grad	cation e completed)		16a. Deced	ent's Usual O kind of work d	ccupation lone during mo etired)	st of worki	ng	16b. Kind o	f Business/I	ndustry
Completed	Elementary/Secondar	y (0-12)	College (1-4o	r 5+)	me. L	O NOT use re	Locksmit				Self En	nployed
B	17. Father's Name (Firs.		Dennis				18. Moth	ner's Name	(First, Middle,	Maiden Sum	. '	
7	19a. Informant's Name/				19b. Mailin	g Address (St	reet and Numl	ber or Rura				ip Code)
	Latoria Webl	b			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4027 Grantley Road Baltimore, Maryland 21215							
	20a. Method of Dispositi	emation 3 🗆 F	lemoval from Stat	0.05	netery, cren	sition (Name on natory or other	r place)		07/18/08	20c. Location	on - City or T Baltimo	
aj l	4 □ Donation 5 □ 21. Signature of □ nera		6	10	1		ddress of Faci	lity		- 17	Balanno	10, 1114.
ő	alligan	Theff	126	Val.	1	Este 130	p Brother 0 Eutaw P	s Funei Place Ba	al Service, attimore, Mo	P. A. d 21217		
	23a. Part1. Enter the di shock of heart fai Immediate Cause (Final	lure. List only of	ne cause on each	line.		er the mode of		s cardiac c	r respiratory ar	rest,		Approximate Interval Between Onset and Death
n al	disease or condition resulting in death)		4-	STRIC		PARCI	001921		7			
r 	Sequentially list condition	ons, t	Lui	us a conseque		TASTA	1315					
xamine	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events	liate	Due to (or a	is a conseque	nce or):							
ш	resulting in death) Last		Due to (or a	s a conseque	nce of):							
edica			l									
Physician/Medical	IF FEMALE: 23b. Was decedent pres	griatit	3c. If yes, outcom	ne pf pregnanc 2 Fetal d		Ectopic pregn	ancv				Date of deliv	
ysici	in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant 9□Unknown	at time of dea		Other (specif					Month	Day Year
by Ph	Part II. Other significan				ng in the un	derlying cause	e given in Part	I.	23e. Did to	bacco use c	ontribute to	the cause of death?
ted b	HYPO	PATE					1 Yes 2 No 3 Probably			bably 4 Unknown		
Completed	7/2031	AIG	- YL					24a. Was an autopsy prior to comperformed?		topsy findings available ompletion of cause of		
0	25. Was case referred to	o medical					26. Plac	e of Death		212/No	1 ☐ Yes	21 7 No
To B	examiner? 1 Yes 2 No	۲	lospital: 1 ☐ Inpa		R/Outpatient				ne 5□Resid			ify)
ition:	27. Manner of Death 1 ☐ Natural 5 [2 ☐ Accident	☐Pending investigation	28a. Date of In (Month, L	Jury Year)	8b. Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐		28d. Describe h	ow injury occ	curred	
Certification:		Could not be determined	28e. Place of in building,	njury - At home etc. (Specify)	e, farm, stre	et, factory, off	fice	2	8f. Location (S City or Tow		mber or Rui	ral Route Number,
	29a. Certifier	Certifying Phys	sician: To the bes	t of my knowle	edne death	occurred at the	ne time, date a	and place	and due to the	auso(s) and	manner ac	otated
Medical	(Check only 2 one)	Medical Exami	ner: On the basis and manner	of examination	n and/or inv	estigation, in	my opinion, de	eath occurr	ed at the time,	date and plac	ce, and due	to the cause(s)
	29b. Signature and title	of certifier		29c. Lic	cense number		2	29d. Date signed (Month, Day, Year) JULY 17 2008				

State Registrar 31. Date filed (Month, Day, Year)

JUL 2 1 2003

DHMH 17 Rev 1/2001

/32. Registrar's Signature

bined from the Medical Examiner must be notified at the Medical Examiner must be notified at the Medical Examiner must be notified at the Medical Examiner must be notified at the Medical Examiner must be notified at the Medical Examiner must be notified at the Medical Examiner must be notified at the Medical Examiner must be not forward must be	1	1. Decedent's Name (First, Middle, Lase ELizabeth Ensor 4a. Facility Name (If not institution, give Dove House 5. Social Security Number 216-70-0586 Usual Residence of Decedent 10a. State 10b. County MD Carrol 1 10e. Street and Number 410 Leefe Farm Drift	ex	Age (In yrs. las 49	st birthday) Yrs.	We		ocation of		2. Date of Deat Month July 5,	Day	Year y of Dea	3. Time of Death 7:35 PM			
Examinet must be notified at the Examinet Director by Elineral Director	•	Aa. Facility Name (If not institution, give Dove House 5. Social Security Number 6. Social Residence of Decedent 10a. State 10b. County MD Carrol 10b. Street and Number	ex □M 2∏ F	Age (In yrs. las 49		We		ocation of		July 3,	7	y of Dea				
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in or items 23a or 28a-f show on character must be notified at the partition of the first of the		Usual Residence of Decedent 10a. State 10b. County MD Carrol 10b. Street and Number Carrol 10b. Street and Number Carrol 10b. Street 10b. Street Carrol 10b. Street 10b. S			Yrs.		1 Year	If Under 24	Hrs. 8	B. Date of Birth		9. Bi	thplace (State or Fore			
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iturel', or items 23a or 28a-f show al Examinar must be notified at act hy Elinaval Director		MD Carrol 1 10e. Street and Number	L	10c. City,									1			
itural, or items 23a or 28a-fs al Examinar must be notifies ad by Funeral Director	unelai Dilecto	10e. Street and Number	L										10d. Inside City Lim			
itural, or items 23a or 21 al Examinat must be no	ulicial Dile		MD Carroll Manc										1 □ Yes 2√			
attent or items 23a sal Examinat must.	uliciai	410 Leele Farm Dr.		10f. Zip Code						1	•	izen of What Country?				
itural, or itemi				21102					USA			adas Indias				
a H	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Force	1 ☐ Yes 2♥ No If Yes, Give 1			Vas Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri				Bla	14. Race - American Indian, Black, White, etc. Specify: White				
	3 -	15. Decedent's Ed		16a, Decedent's Usual Occupation						16b. Kind			of Business/Industry			
u ga	2	(Specify only highest gra		(Give kind of work done during most of life, DO NOT use retired)				f working	working							
	5	Elementary/Secondary (0-12) College (1-4or 5+) 12 2 accountant									f	financial				
ent, ent		17. Father's Name (First, Middle, Last)						18. Mother's	Name (First, Middle, I	e, Maiden Sumame)					
Mental arked c atic eve		William Noah En	sor					7	ruth	n Rodke	у					
and Men ia marke aumatic			19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailing	g Address	(Street ar	nd Number	or Rural	Route Number	City or Town	, State,	Zip Code)		
alth a		Truth Ensor/moth	er		P.O.	Box	368 1	68 Manchester, MD 21:				.102				
nent of Health int: if item 27 i iry or other tra	-	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Specify		007	ce of Dispos netery, crem	ition (Nan atory or o	ne of ther place)	Da	te	20c. Location	- City o	Town, State			
Department of himportant: if ite any injury or of once.		21. Signature of Funeral Sectice Licen	Wad, Vii	rector				my Boa		655 W.	Baltim	ore	Street			
	hysician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	b. Seps	as a consequent S as a consequent as a consequent	nce of):		-0-						6/26/08-7			
by the attending lacked for use as		/ Physician/Medic	y Physician/Medi	y Physicianumeur	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown ontributing to death but not resulting in the underlying cause given in Part I.						23d. Date of Month 23e. Did tobacco use contribute			Day Year	
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ate has been signed to page 2 should be detected to be a should be detected to be a should be by placed by		ompiete	эзысшо	-							a			topsy prior to completion of o		completion of cause
director, pag		25. Was case referred to medical examiner?						26. Place o	f Death (Check only on	θ)					
isi isi	27. I	1 ☐ Yes 2 ☐ ¥0 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of 28c. Injury at Work?					28	ne 5 Residence 6 Mother (Specify) Cove			ecity) Povett				
offer deal		2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28	Bf. Location (St City or Town	treet and Num n, State)	ber or F	Rural Route Number,			
Funer Funer ely fill	מוכם	(Check only 2 Medical Exam	ysician. To the be niner: On the basis and manner	of examination		estigation,	, in my opi	nion, death		d at the time, d	ate and place	and du	e to the cause(s)			
within 2 To the complet	=	29b. Signature and title of certifier	D .	•			. License			2	9d. Date signe	ed (Mor	itn, Day, Year)			
		* Kolant K	the n	10, Ph	n		D00	6459	7		+19	10) K			
	1	30. Name and address of person who	completed cause o	death (Item 2	3a) (Type, P	Print)	1	C.			•		021157			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 16, **Physician** 2008 1:30 p. M Consuelo D. Franquelli /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. FutureCare East Point Dundalk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/19/1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Philippines 1 □ M 2 🕱 F Months Days Hours Min 86 Director 328-42-1071 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 524 N. Charles St. Apt. 1016 21201 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Professional Singer Musician 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be 2 Leandro Franquelli Antonia Devesa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 N. Charles Street Apt. 1016 Baltimore.MD 21201 Angelica Franquelli /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 1 Other (Specify) Entonoment 07/18/2008 Baltimore, Maryland Oak Lawn Cemetery 22. Name and Address of Facility Michael E. Canapp 5305 Harford Road Baltimore, MD Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any learning to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 1 ☐ Yes 2 [9 ☐ Unknown 5 ☐ Other (specify) the detached 9□Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Jas page 2 certificate 1□ Yes 212 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 **□** No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t the Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Woods 31. Date filed (Month, Day, . Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 14, 2008 5:30 P^M MARY MAUDESSA FLOWER July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Genesis Eldercare Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/09/1925 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🕶 F Yrs. Carolina 219-10-5986 82 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7975 Crain Highway 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ₩Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Brazzle Maggie Brazel ပ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Allen Flower/Son Greenway Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of P Important: If ite any Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07/18/08 Cedar Hill Cem Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Ent - the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final METASTATIC MONTAS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, is a unity to minimum sonate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed 2 4No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, D31136

Registrar

A

32 Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month NILLENE GARNER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bon Secours Hospital BALTIMURE 5. Social Security Number 247-72-0859 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)

4. Yrs. 8. Date of Birth **Funeral** 1 ☐ M 2 🕦 F Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner πust be notified at Baltimore 1 Yes 2 □ No Director Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 Hvenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married r than "natural", or the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other that any injury or other traumatic event 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ba Ho, onD 21217 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 7.24.08 Owings Mills, MD 21. Signature of uneral Service Licenses aughter Greene Funeral Services SI Batto. Nat' | P:10 (21229) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Box 68760, Physician/Medical for use a IF FEMALE: If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has perform 2 MNo Division or Vital 1 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Funeral Directo 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Ho within 24 h To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 West Baltimore Street

State Registrar

DHMH 17 Rev 1/2001

Hegistrar JUL 2 1 2008

Marganta

31. Date filed (Month, Day, Year)

Baltimore, MD 21223

B. Jovel

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** July 17,2008 Mary Gilley 0800 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ivy Manor Assisted Living Ellicott City
If Under 1 Year | If Under 24 Hrs. Howard 8. Date of Birth (Month, Day, Year) 06/01/1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1□M 2 F Days Hours Maryland 91 Director 577-01-0987 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once, 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2X No Director Maryland | Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 1434 Gibsonwood Road 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company 12 Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hester Anne Hoffman Robert Wardell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1434 Gibsonwood Road Catonsville, Maryland 21228 James L. Gilley - Son 20b. Place of Disposition (Name of cemelery, crematory or other place)

Lorraine Park Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 07/22/2008 Baltimore, Maryland 21. Signature of Funeral Service Licens 22 Name and Address of Facility
David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest chock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as yo insequence of): yea **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be execute and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) P.0. ed by the a 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, by 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been (24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 Allo cate has l certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Was ted 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P neral Director: After this y filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28c. Injury at Work? Certification: Division Attending Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide determined 4 ☐ Homicide To the Hospital or within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 724 Maiden Choice La, Catansfille MD Raafat M.D 31. Date filed (Month, Day, Year) Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Frank Goodwin 2008 19.07 PM JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD SAMARITAN BALTIMORE HOSPITAL N/A If Under 1 Year | If Under 24 Hrs. | Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M_k 2 □ F Director 214-50-1676 Nov 3, 1945 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hatural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantins must be notified at once. Director 1 □ Wes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 337 East Lorraine Avenue 21218 U.S.A by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Washington Flour Company Lineman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilford Goodwin Margaret Bailey ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura A. Goodwin 337 East Lorraine Avenue Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Borial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/19/08 Windsor Mill, Md. King Memorial Park 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217

Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMONIA ASPIRATION Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transit resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) ed by the a detached f 1 □Yes 2 □No 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š DISEASE STAGE FEMAL CARDIOMYDPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed DIABETES MELLITUS HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

P.0. FRANK Vital o

Box 68760, Records,

400DWIN Division

with the Maryland

Baltimore, Maryland 21215-0036

the death certificate be executed After this (funeral dir To the Hospital or Attending · death. ieral Director: A after within 24 hours a

To the Funeral C

completely filled

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

RES-000

29d. Date signed (Month, Day, Year) JULY 14 2008

30. Name and address of person who completed cause of death (nem 25a) (type, Fillit)
203AIK SHAIKH, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE, MD -21239

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

6 ☐ Could not be

determined

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c per fib. 881 7-19-08 vt. State of Maryland Department of Health and Mental Hygiene 2 0 0 8 amend item 2 per doc 881 rificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Peath 3. Time of Death **Physician** Year LURIA GREENF 6720 08 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE WASHINGTON ANNE ARUNDEL

9. Birthplace (State or Foreign
Country)

NORTH CARCINA GLEN MEDICALCENTO BURNI If Under 1 Year | If Under 24 Hrs. 5. Social Security Number de (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖫 F Months Days Hours Min 212-44-4245 Yrs **Director** 7.16.44 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director Yes 2 □ No EVERN MD ANNE ARUNDEL 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21144 INITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ es 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 →No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene, 27 is morked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 🚣 Be 18. Mother's Name (First, Middle, Maiden Surname) uld be fi မ STAC and 2 sho 19a. Informant's Name/Relationship, (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8132 SEVERN Department of Health Important: If item 27 any Injury or other troops. URIA GREENE 5140 MD DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other pl 20a. Method of Disposition Pages 1 20c Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of acility ER'S METROPOLI BAITO, MD 21213 6 BROADWAY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMYOPATHY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner FAILURE CONGESTIVE HEART Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the timeral director, page 2 should be detached for use as the burlat-transit HYPERTENSION Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical SCHLERGDERMA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 □No 1 □Yes 2 **(7)** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No Certification: To 1 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Iniun 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S. Chaudry DS5113 7.1.08 21061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAJIDA CHAUDIRY HOSPITAL DR. GLEN BURNIE 301 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23330 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 530 AM uncu tubbai 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA (EAST) BalTimore Square Larue If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 20-24-265 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Comptry? Square Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) HOSPITE1 KegisT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) liam (Arring Ton Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husbard 3018 Larus Sa BBARD East くしゃい 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07-22-08 4 Donation 5 □ Other (Specify) (tom 22. Name and Address of Facility 21 Sign ture of Funeral Service License wa 4600 UBERTY I SAT BEITO No 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 carolias /Medical Due to (or a consequence of): Examiner Amyloidosis Sequentially list conditions Due to (or as a Consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the t IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗖 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has funeral director, page 2 autopsy performed? 1 Yes 2 No certificate the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20052490 Coule Chandelwal is) July 18, 2008

Registrar
DHMH 17 Rev 1/2001

State

South Hunovy St Bultonin MD 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Khande/wal MD

2 1 2008

31. Date filed (Month, Day, Year)

08-05149 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene Tarika Hood 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) Reg. No Physician/ 2. Date of Death Month Day July 5, 2008 **Medical Examiner** 0050 hrs Tarika Hood 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1315 North Carey Street **Baltimore** 5. Social Security Number If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or **Funeral** 7. Age (in yrs. last birthday) Foreign Days Hours Director Country) 1XXM 2 F 213-80-3360 7/1971 Md. 37 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No 28a-f show Md N/ABaltimore Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2809 Oswego Avenue USA 21215 Funeral 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes 3 Widowed Divorced If Yes, Give Year Specify: Black Yes 2 X No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Austin Gregory Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 should be filed within and Mental Hygiene. Masonry Company Skill Worker 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) If item 27 is marked Be Bernard Hood, Sr Lucinda Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number; City or Town, State, Zip Code) permit. Pages I and 2 sl Department of Health an Important: If item 27 injury or other trauma 58 Shropshire Court, Reisterstown, Md. LaTonya Hood 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 7/16/2008 Metro Crematory Catonsville, Md. Other Specify: Donation 5 21. Signat ²² Name and Address of Facility Estep Brothers Funeral Service, PA 1300 Eutaw Place, Baltimore, Md. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician art I. Enter the disease or con Approximate Interval failure. List only one cause on a Between Onset and /Medical Death aHeroin intoxication Immediate Cause (Final disease ≒xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical #23a,PIi,27,28a-f, perMe, g881 7/22/08 TT X UNPENDED attending physician or use as the burial AMENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 V Unknown Cocaine use Completed 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other; Nursing Home 5 ___ Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 Yes After 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: Natural 1 Director: Yes 2 X No unk death. Pending Fnd 7/5/08 Fnd 12:30 2 Accident Investigation within 24 hours after de To the Funeral Direct completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1315 N. Carey St Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide found at front door (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

OCME 2006

Registra DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

Russell Alexander MD.

31. Date filed (Month, Day, Year)

MB

Assistant Medical Examiner

32 Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a)

2008

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 5, 2008

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Month 2002 **Physician** M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 212-86-6897 32 MI 1975 **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at AI 1 IMOr Director Yes 2 □ No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Co atry? tre 5 d Funeral 12. Was Decedent Ever in U.S. Armed Forces?/
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🚺 No Specify ģ 3 Widowed 4 Divorced 0 "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry the Medical (Specify only highest grade completed) and 2 should be filed within ifealth and Mental Hygiene.
m 27 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) 18 Be tumbles ne 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1504 RO B2 1770 nt of Health 21206 9 5920 Schering MShanica 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremator) or other of Date 20c. Location. City or Town, State 5 permit, Page Department of Important: If any Injury or 07-22-08 0: Crema wure of Funeral Service License 22. Name and Address of Faility Home 4600 WBERZ 21207 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Related Cardiomyopathu Immunaleficiency 11ins-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Il Records, P.O. Box 68760, The law requires that the death certificate be executed Exami burlal-transit that initiated events and Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical use as attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 1 Tyes 2 1 No 1 Yes 2 No certificate Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes _2 **□** No 1 Inpatient 2 ER/Outpatient 3 □ DOA 2 this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Y 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending investigation ieral Director: Af М hours after death. 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) 24 hours 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical pletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD Name and address of person who completed cause of death (Item 23a) (Type, Print) Leidne Soms 146/PCINS 600 North Wolfe St, Baltimore, MD, 21287

Registra

State

31. Date filed (Month, Day, Year)

2008

DHMH 17 Rev 1/2001

Davec.

32. Registrar's Signature

			Please	Type or Prin						-			
		For State Registrar		State of Ma	aryiano		artment of H <i>rtificate of L</i>			Jiene leg. No. 2 N N S	3 2 3 3 3 3		
Physici	400	1. Decedent's Name	(First, Middle, L	•					2. Date of Dea		3. Time of Death		
/Medic Examin Funeral Director			not institution, g	ive street and number)	e (<i>In yrs. la</i> : 96		4b. City, Town, or If Under 1 Year Months Days	Location of Death SV 1 If Under 24 Hrs. Hours Min.	e Date of Birth	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)			
tand on		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or L	ocation		10d. Inside City Limits				
e Mary 3a-f sho tiffed a	ctor	MD	Baltime	ore	С	atons	ville			1 □Yes 2√□No			
ath with th 23a or 28 ust be no	Funeral Director	709 Maid		ce Lane RGS	10f. Zip Code 21228					10g. Citizen of What Country? USA			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: I flem 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	۵	11. Marital Status 1 □ Never Marrie 3 ₩ Widowed		12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		i. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 No Specify:			ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.		
hin 72 ho e. an "natur Medical.	To Be Completed	(Speci	15. Decedent's lify only highest g	ducation ade completed) 16a. [College (1-4or 5+)			dent's Usual Occupa e kind of work done of DO NOT use retired	ation during most of work f)	ing	16b. Kind of Business	s/Industry		
Hygiene Hygiene her the nt, the	Con	12 17. Father's Name (2		te	acher	18 Mother's Nam	a (Firet Middle	educati Maiden Surname)	on		
ld be fi lental H ked ot Ic ever	o Be	Joseph M		51)					rine Dan				
nd 2 shou lith and M 27 Is mar r traumat		19a. Informant's Na Patricia		(Type. Print) daughter			ing Address (Street a		ral Route Numbe Columbi	r, City or Town, State, a, MD 210			
Pages 1 ar				□Removal from State			osition (Name of matory or other place		Date	20c. Location - City o	r Town, State		
permit. Departn Importa any Inju		21. Signature of Fur	neral Service Lic nthony	Pleasant	ut		2. Name and Addres State Anat Baltimore	-		. Baltimor	Street		
by Medicate be executed attending physician and attending physician and for use as the burial-transit	dical Examiner	shock, or hear Immediate Cause (f disease or condition resulting in death) Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	nt failure. List on Final n n n n n n n n n n n n n n n n n n	b. Due to (or as Due to (or as d.	a conseque	ence of):	ria			isease	Interval Between Onset and Death		
The law requires that the death certificate be ate has been signed by the attending physicis agge 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 to 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal of	death 3	□Ectopic pregnancy	/		23d. Date of d Month	elivery Day Year		
juires that the de n signed by the a ild be detached i	þ	Part ii. Other signifi	icant conditions	contributing to death b	out not result	ting in the (underlying cause give	en in Part I.	23e. Did to		to the cause of death?		
	Completed												
certifica ector,	Be	25. Was case referr examiner?		Hospital:			ot sci pos Othe	26. Place of Dear	th (Check only o	ne)			
g Phys er this eral dir	n: To	1 ☐ Yes 2 ☐ 27. Manner of Death	h	28a. Date of Inju	ıry 2	R/Outpatie	TIL 3 DOA	4 Lakersing H		lence 6 Other (Sp low injury occurred	ecify)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	1 □ Hafural 2 □ Accident 3 □ Suicide 4 □ Homicide	5 ☐ Pending investigati 6 ☐ Could not determine	be 28e. Place of inj		Injury ne, farm, si		Yes 2 □ No	28f. Location (S City or Ton	Street and Number or I n, State)	Rural Route Number,		
ne Hospital	Medical Ce			Physician; To the best aminer: On the basis o and manner st	of examination								
To the within To the Comp	M	29b. Signature and	title of certifier	a, N	N		29c. Licens	700 9		29d. Date signed (Mod July 15			
Sta	ite_	Name and address	o St	o completed cause of c	death (Item a	May	den C	hoice	-ane	Baltima	, 2008 reMDZ12Z8		
Registi	ar	J	UL 21	2008 Ane	a l	1 A	226						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 23334 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}008 July 13, 9:05 PM M James Hutton 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 24, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 215-62-6724 63 1944 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1√TYes 2 □ No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 N. Clinton Street 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11, Marital Status unk Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2X No 1 ☐ Yes 2X No Specify: white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Hutton Shirley Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Bostik/brother in law 2435 Appaloosa Way Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other(Specify) in state Anthony Pleasant State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -UNO CANCEN disease or condition resulting in death) Due to (of a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown

Examiner James + Lutton 7/13 Division or Vital Records, P.O. Box 68760,

Examine ending physician and use as the burial-tran Physician/Medical atter for u signed by the a ģ Completed peen page 2 s certificate Be 2 within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral Certification: or Attending Medical

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

within 72 hours after death

d 2 should be filed with and Mental Hygier 7 is marked other the

Pages 1 and c. tment of Health a

Department of important: If it any injury or o

Physician

/Medical

Baftimore, Maryland 21215-0036

_										1	24a. Was an autopsy performed? □ Yes 2	24b	prior to cor death?	psy findings a mpletion of ca 2□ No	
25.	Was case refer	red to medical		26. Place of Death (Check only one)											
	examiner?	No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home								me 5 Residence Dother (Specify) Hospice				ce
	Mann of Death 1	5 Pending investigation	1	. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes	2 🗆 No	28d. D	Describe how inj	ary occi	urred	- /	
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286	 Place of injury - At h building, etc. (Speci 		et, fact	ory, of	ffice			ocation (Street a City or Town, Sta		mber or Rura	I Route Num	ber,
29	a. Certifier (Check only one)		niner: O	To the best of my kn n the basis of examin nd manner stated.											5)

mo

29c. License number 29d. Date signed (Month, Day, Year) 100587

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RiBinson 838 Nocto Buldimeny Entran Street

State Registrar 29b. Signature and title of certifier

7. Age (In yrs. last birthday)

87

Yrs.

10c. City, Town or Location

Certificate of Death

Months Days

4b. City. Town, or Location of Death

Gaithersburg

the Maryland or than "neturel", or Items 23s or 28s-f show the Medical Examiner must be notified at Director 10e. Street and Number 10f. Zip Code 3612 Spring Street 20815 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "neturel", or Itel 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filment of Health and Mental Hism 27 le marked ot! Thomas Garrett Mowry 19a. Informant's Name/Relationship (Type, Print) Robert Glenn Hall/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 20, 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of 4 □Donation 5 □ Other (Specify) Montgomery Crematorium 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☐ No 3 Eclopic pregnancy 4☐ Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions conjugating to death but not resulting in the underlying cause given in Part I. δ Be Completed 24a. Was an page 2 Aceplenou Inem. 25. Was case referred to medical 26. Place of Death (Check only one exammer?
1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funerel Director; A investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one)

201 RUSSELL 64 MITHERSBURGIND 208

DHMH 17 Rev 1/200

State Registrar

If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours Min March 18, 1921 South Dakota

2008

4c. County of Death

Montgomery

Reg. No.

2. Date of Death

July 18,

23335

3. Time of Death

3:00 P M

10d. Inside City Limits 1 ¥ Yes 2 □ No

Chevy Chase 10g. Citizen of What Country?

United States Race - American Indian, Black, White, etc.

White Specify:

16b. Kind of Business/Industry

Own Home 18. Mother's Name (First, Middle, Maiden Sumame)

Sara Cuthbertson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3025 Mozart Drive, Silver Spring, Maryland

20c. Location - City or Town, State Bethesda, Maryland

22, Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814

Approximate Interval Between Onset and Death

Hypertensive arteries clestic Cardoragerelar Due lo (or as a consequence of):

Month

23d. Date of delivery

Day

Year

23e. Did tobacco use contribute to the cause of death?

3 ☐ Probably 4 ☐ Unknown 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

32 Registrar's Signature

1 - State Registrar

10a Stale

Maryland

5. Social Security Number

491-22-3934

Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

Mary Margaret Hall

4a. Facility Name (If not institution, give street and number)

10b. County

Wilson Health Care Center

Montgomery

6. Sex

1 ☐ M 2 🛱 F

29b. Signature and title of certifie

>/ Rehest Br

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H.ROBERTBIRSCHBACH

31. Date filed (Month, Day, Year) _

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:15AM M July 18, 2008 Mary Honore Heinemann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville ar | If Under 24 Hrs. Hebrew Home Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Dav. Year) Funeral Months Days Hours 1 □ M 2 🕱 F Yrs. September 4, 1911 Washington, D.C Director 96 145-01-5762 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notifled at 1 ☐ Yes 2 No Director Maryland | Kensington Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20895 Frederick Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Framinance. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Specify <u>م</u> 3 ☑ Widowed 4 ☐ Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 James Wickham Susanna Stamm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 936 Nichols Drive, Laurel, Maryland 20707 Charles B. Heinemann, III/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date n Memorial Park 23, 2008 Rockville, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) endrova seedar Accepent Physician week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 4 O 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0036716 July 18,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6121 Montrose Road, Rockville, Maryland 20852 M.D. Andrew Kundernt, 31. Date filed (Month, Day, Year) State 2008 JUL 21

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Day **Physician** :45 PM Johnson Lsidro 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Months Days Hours 37 219-94-8910 Director JULY 29,1970 MD Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at Director Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 2794 THE ALAMEDA 21218 USA Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yes 2 K If Yes, Give Year or Dates: 72 hours after 1 🕅 Never Married 2 ☐ Married 2 No ö 1 ☐ Yes 2 😿 No Specify: à Specify: 3 Widowed 4 Divorced BLACK "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical d 2 should be filed within 7, h and Mental Hygiene. 7 is marked other than "ns Elementary/Secondary (0-12) College (1-4 or 5+) 9 HANDYMAN HOME IMPROVEMENT permit. Pages 1 and 2 should be file Department of Heath and Mental Hy, Important: If Item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å MATTHEW DUNN DEBORAH **JOHNSON** ည Α. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALMA JOHNSON/GRANDMOTHER 2794 THE ALAMEDA BALTIMORE, MARYLAND 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARBUTUS MEMORIAL PK. 7-23-2008 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MARYLAND 23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Multi-system organ /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit resulting in death) Last Due to (or as a pinsequence of): Physician/Medical 515 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? 1 Tyes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) funeral (27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide

Box 68760, P.0

Baltimore, Maryland 21215-0036

death certificate be executed The law requires that the Division of Vital Records, or Attending death. I Director: A after filled in

To the Hospital o within 24 hours af To the Funeral DI completely filled in

State Registrar

Could not be

determined

4 Homicide

(check only one)

29b. Signature and title of certifier

29a. Certifier

Medical

29c. License number 29d. Date signed (Month, Day, Year) 08

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GABRIE 31. Date filed (Month, Day, Year)

and manner stated.

Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

28f. Location (Street and Number or Rural Route Number,

1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Wands Ra	Nelly Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
UNK UNK	State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No. 2008 233
Physician Medical Examine	Month Day Year 1205 has
Messical Examine	Wanda Rochelle Johnson June 27, 2008 4a. Facility Name (if not institution, give street and number) June 27, 2008 4b. City, Town, or Location of Death 4c. County of Death
<i>x</i> .	13914 Castle Boulevard Silver Spring Montgomery
Funeral Director	5. Social Security Number unk 6. Sex 17. Age (In yrs. last birthday) 1 Months Days Hours Min. Feb 2, 1962 Country) 9. Birthplace (State or unk Foreign Country)
ow any	Usual Residence of Decedent 10a. State unk 10b. County 10c. City, Town or Location 1 Yes 2 N
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number Unk 10f. Zip Code unk 10g. Citizen of What Country? USA
Baltimore, MD 21215-0036 Permit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	11. Marital Status UNK: 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
5-0036 64 within 72 hours: tygiene. other than "natura be Medical Exami	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	
MD 21 ad 2 should 1 ath and Mer m 27 is mar aumatic ev	O.C.M.E. 111 Penn Street Baltimore, MD 21201
Baltimore, pernit, Pages I at Department of Hea Important: If the injury or other tr	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State
	22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
	Sequentially list conditions b.
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
50, te be execute yysician and burial - tran	X UNPENDED #23a,27,perME,g881 7/22/08 TT IF FEMALE: 23c, If yes, outcome of pregnancy 23d, Date of delivery
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed hours after death. Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial of the Completed by Divisional Modical	23c. If yes, outcome of pregnancy 23c. If yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of
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Division of Vital Records, later dear requires after dearn. The law requires after dearn. After this certificate has been signed in by the funeral director, page 2 should be partification. To Re Commisted	24a. Was an autopsy findings available autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysteian: The his certificate director, page	25. Was case referred to medical examiner? 26. Place of Death (Check only one)
of Viring Physical After this funeral dir	1 Ves 2 No Total 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene
on c ending ath. rr: Aff he fun	1X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No
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Division of To the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) June 28, 2008
	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Stat Registra	31. Date filed (Month, Day, Year) 32. Refistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		rtificate of Death	Reg. No.	2008 23339
Physic /Med		1. Decedent's Name (First, Middle, Last)	KNIGH	_	2. Date of Death Month Day	3. Time of Death
Exami		4a. Facility Name (If noninstitution, give street and no		4b. City, Town, or Location of Death	4c.	County of Death
Funera Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
Maryland f show	ior	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation (10d. Inside City Limits 1 □ Yes 227No
with the A a or 28a-	Direct	10e. Street and Number	Life .	10f. Zip Code	10g. Citi	zen of What Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evancine, must be notified at more.	y Funeral Director	1 □ Never Married 2 Married Armed F	2 No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036 within 72 hours aff giene. er than "natural", or the "redical Expri-	Completed by	3 U Widowed 4 U Divorced Year or 15. Decedent's Education (Specify only highest grade completed)	Dates: 16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b. Kii	nd of Business/Industry
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Baltimore, permit. Pages 1 a Department of Hei Important: If item any injury or othe		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	Arbertu.	Scane for San Facility	reene F	lp.M.D
m gg E g		23a. Part 1. Enter the disease, or complications that	caused the death. Do not en	4905 Lock ter the mode of dying, such as cardiac	The Ball or respiratory arrest,	Approximate Interval Between
Physician /Medical	•	shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)		- brust corner		Onset and Death
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of Vita hysician his certif	To Be		☐ Inpatient 2 ☐ ER/Outpatie		th Check only one) ome 5 Residence	6 ☐ Other (Specify)
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Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 a	Certification: To		ce of Injury - At home, farm, st ding, etc. (Specify)	0	City or Town, State	1
he Hosp in 24 hou he Fune pletely fi	Medical	(Check only 2 Medical Examiner: On the	he best of my knowledge, dea basis of examination and/or in anner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the cause(s rred at the time, date and	s) and manner as stated. d place, and due to the cause(s)
To th	Ž	29b. Signature and title of certifier		29c. License number	29d. Da	te signed (Month, Day, Year)
5		30. Name and address of person who completed ca	use of death (Item 23a) (Type	, Print)		Bultima MD 21237
s	tate	31. Date filed (Month, Day, Year)	Registrar's Signature	710s tranklin	gune by	12 MING MI 2125F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 JOSEPH KREJCI JULY 17 7:15P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 214-01-5292 1 M 2 □ F 93 1-12-1915 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☑ No MD HARFORD FOREST HILL 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1226 BEAR HOLLOW COURT 21050 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 🎾 No Specify Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WESTERN ELECTRIC MACHINIST 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (BOUDA) JACOB KREJCI ANNA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DALEVIEW CT TIMONIUM, MD RICHARD KREJCI/SON 101 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛮 Cremation 3 ☐ Removal from State 7-19-2008 CATONSVILLE, MD METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final small Bowe west disease or condition resulting in death) Due to (or as a consequence of): westes tor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events CATheta p(Acemen1 weeks resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Ye ar 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ot Concer History MELMOMA orostate 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? HOSPICE ther (Specify)

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/Medical

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Medical Certification: To

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Item 27

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Baltimore.

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IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

4 Homicide

31. Date filed (Month

			26. Place of Dea	th (C	heck only one)	
Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 □ DOA	Other: 4 Nursing H	lome	5 Residence	6 🗷
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27. Manner of Death (Month, Day, Year) Injury 5 ☐ Pending investigation 1 Natural 2 Accident 3 ☐ Suicide

Work?

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investigation

6 Could not be determined

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City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

1)25205

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N- Charles St. Bolto.

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year LOCKETT. PM :53 TULY MAMIE 6 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) FRANKLIN WOODS CENTER timore 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Days Min. Hours Months 1 M 2 K 241-28-636 Usual Residence of Decedent 10c. City. Town or Location 10b. County =doewood 10g. Citizen of What Country? 10f. Zip Code 21040 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Specify: Specify:

Department of Health Important: If item 27 other Baltimore. Pages 1 ö injury uny in **Physician**

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or Items 23s or 28s-1 show the Medical Examiner must be notified at

filed within 72 hours after death

Hygiene.

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Maryland 21215-0036

burial-1 attending physician for use as the buria ed by the a detached f signed by i been page 2 has certificate this

/Medical Examiner death certificate be Physician: I Diractor: After this of in by the funeral of death. within 24 hours after 0 To the Funeral

Physician/Medical by Completed Be 2

P.0. Records, Vital of

> State Registrar

31. Date filed (Month, Day, Year)

2 1 2008

10d. Inside City Limits 10a. State 1 Tes 2 70 **Funeral Director** 10e. Street and Number 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education fy only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ecologary (0-12) College (1-4or 5+) e 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 0 nnie Good 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ane, Basto MD 21237 20b. Place of Disposition (Name of 20c. Location - City or Town, State Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 3/08 4 □ Donation 5 □ Other (Specify) PENMOUNT 21. Signature of Puneral Service Licensee P2 Name and Address of Fall Vought Company 4905 Chui Theene Tuneral Service e Fung Ful Sorvices 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode **ru**g, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADVANCED DEMENTIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Liner Uriderly is Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURF ACUTE 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 🗆 Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 TNo 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier In Awich mp 00061789 JULY 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LORRAINE OFORI AWUAH, MD, 5430 CAMPBELL BLVD, STE214, BATIMAKE 21236

32. Registrar's Sanature

Teller-

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** June 27. 2008 Virginia Lyon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Montgomery 01ney 8. Date of Birth (Month, Pay, Year) July 17, 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours Min. 1 ☐ M 2 🔽 F 89 July Director 363-09-2805 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show important; if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic event, the Medical Examinar must be notified at any once. Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14635 Bauer Drive #304 20853 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ≥ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Lyon ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Shelter Cove Road Milford, CT 06460 Dorothy Wilcox/cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Licenses Leasant Teasan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certific te has been signed by the attending physician and attending physician

IF FEMALE

23b. Was decedent pregnant

9 Unknown

29a. Certifier

in the past 12 months?
1 Yes 2 No

Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

3 Ectopic pregnancy 5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene)

23d. Date of delivery

3. Time of Death

4:00 PM M

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 🔀 No

unk

unk

Approximate Interval Between Onset and Death

Country) Michigan

white

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BILATERAL HIP FRACTURES DUE TO FALL,

1 Live birth 2 Fetal death 4 Pregnant at time of death

FAILURE RHABBOMYOLYSIS

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an

Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 2 🗆 No 1 □ Yes 1 ☐ Yes

23e. Did tobacco use contribute to the cause of death?

>	Fait II. Other significant conditions (onthibuting to u
q p	ACUTE MI, BI	LATERA
Somplete	RENAL FAILURE	RHAL
ro Be (25. Was case referred to medical examiner? 1	Hospital: 1
Certification: To Be Completed by	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not b determined	100
U		

Date of Injury (Month, Day, Year) 5 | Pending investigation 06 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

inpatient 2 ER/Outpatient 3 DOA 28b. Time of UNK.

28c. Injury at Work? 1 ☐ Yes 2 No

26. Place of Death (Check only one)

TIFICATION

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
FELL WHILE CARRYING A TRAY TO THE KITCHEN

Location (Street and Number or Rural Route Number, City or Town, State) ROCKVILLE, Mb 14635 BAUER DR. ATT 304.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

20853

NA

HOME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ULZ

OLNEY, PRINCE PHILIP DR 20832

State Registrar

אייפי יחוא sertificate has been signed by funeral director, page 2 should be detach

Medical

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within 24 hours a

To the Funeral D

completely

P.O. Box 68760

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep	ertment of Health and Nertificate of Death		2002 23344
		Registrar 1. Decedent's Name (First, Middle, Last)	Timeate or Death	Reg. N	3. Time of Death
Physicia				Month D	ay Year
/Medic Examin		Margaret E. Lohr 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	P 41 1	2008 9:00 a M
Examili	eı	Carriage Hill Bethesda	Bothooda	M	ontgomory
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Yea	ontgomery 9. Birthplace (State or Foreign Country)
Director		579-26-2211 1□M 2X F 83 Yrs.	Months Days Hours Min.		, 1924 Maryland
p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1	anation	•	10d. Inside City Limits
larylan show	_	10a. State 10b. County 10c. City, Town or I	cocation		1 ☐ Yes 2 ☑ No
he M 28a-f otifie	Director	Maryland Montgomery B 10e. Street and Number	ethesda	100.0	Citizen of What Country?
ind Z 1 Z 1 Z 20000000000000000000000000000			10f. Zip Code		
eath	Funeral	5215 West Cedar Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (St	Decify Yes or No-	ted States 14. Race - American Indian,
fter d r item	듄	1 □ Never Married 2 □ Married 1 □ Yes 2 ➡ No	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	Black, White, etc.
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d will	Į.	12	Homemaker		Own Home
yiding 2.12 buld be filed withi Mental Hygiene. arked other than aric event, the M	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maide	en Surname)
y ca	၉	Joseph H. Oden		e C. Daymu	
2 should be filed v and Mental Hygie Is marked other t raumatic event, th		19a. Informant's Name/Relationship (Type. Print)	ling Address (Street and Number or Ru	ıral Route Number, City	y or Town, State, Zip Code)
D = C +		Valerie P. Bradshaw/ Neice 1600	9 Bonnie Bank Terr	ace, Darnes	stown, Maryland 20874
ges 1 Fof H		20a. Method of Disposition 1 ☐ Burial 2 ဩCremation 3 ☐ Removal from State 20b. Place of Discemetery, co	position (Name of ematory or other place) July	y 18,	Location - City or Town, State
Pag ment ant: jury		4 □ Donation 5 □ Other (Specify) Montgomery	Crematorium Trc. 200		hesda, Maryland
permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		21. Signature of Furieral Service Licensee	22 Name and Address of Facility Obert A. Pumphrey	Funeral Home	e/Bethesda-ChevyChase,Inc.
- 70= 40	Н		557 Wisconsin Ave.		Maryland 20814 Approximate
		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiad	or respiratory arrest,	Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death) a. Arrhythria			
/Medical Examiner		Due to (or as a consequence of):			
	<u>ا</u>	Sequentially list conditions, if any, leading to immediate b. Heart Disease Due to (or as a consequence of):			
red te. (i i	Cause (Disease or injury			
execu execu end	Examiner	that initiated events resulting in death) Last C Due to (or as a consequence of):			-
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ifficate g phy as the	edi				
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery
death death	icia	in the past 12 months? 1 Ves 2 17No 4 Pregnant at time of death	□Ectopic pregnancy □Other (specify)		Month Day Year
by the	hys	9 ☐ Unknown			
s tha	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
w requires to been signer should be a	ad k	Alzheimer's Disease		1 ☐ Yes	2 No 3 Probably 4 ∏Unknown
law re as bee	Completed			24a. Was an	24b. Were autopsy findings available
The I	E O			autopsy performed 1 Yes 2 🔀	
vican iclan: Ticlan: Techificat ector, pa	0	25. Was case referred to medical	26. Place of Dea	ath (Check only one)	10 100 2010
ysicl ysicl is cel	To B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	ent 3 DOA Other: 4 X Nursing H	lome 5 ☐ Residence	e 6 ☐Other (Specify)
ig Ph		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)		28d. Describe how in	njury occurred
Attending or death. ector: Afte by the fune	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
ital o	ခြွ				
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only (C			
the hin 24	Medi	one) and manner stated.			
Wit To	-	29b. Signature and title of certifier	29c. License number	290.1	Date signed (Month, Day, Year)
		IM	D35579	J	uly 17, 2008
Q		30. Name and address of person who completed cause of death (Item 23a) (Typ			
U		Susan J. Miller, M.D. 8218 Wisconsin 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Avenue #305, Bethe	esda, Maryl	Land 20814
Sta Registi		31. Date filed (Month, Day, Year) 32. legistrar's Signature 33. legistrar's Signature	ands!		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death **Physician** 1203 Harr y Long 2008 אר טל 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Johns Hopking Beywiew Medical Center Baltimore 8. Date of Birth (Month, Day, Year) NOV. 24,1939 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 3 M 2 □ F Director 217-38-3120 68 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2\TXNo Directo Baltimore Dundalk Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 United States 7811 Deboy Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1961 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. ੬ Specify: 1961**-**67 White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. GNB Elementary/Secondary (0-12) College (1-4or 5+) Service Tech Industrial Battery Year t. Pages 1 and 2 should be filed v treent of Health and Mental Hygie tant: If item 27 is marked other i jury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gladys Hill Harry Long 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dundalk, Maryland 21222 Mrs. Kathleen E. Long (Wife) 7811 Deboy Ave. Baltimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important; If any Injury or 7/21/2008 Crownsville, MD Crownsville Cemetery: 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. CO-5075 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEPTICEMIA AND SHOCK **Physician** disease or condition resulting in death) /Medical - Coutis ma PERITORITIS
ATherosclerotic Disease as a consequence of) **Examiner** Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) physician Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐ Pregnant at time of death
9☐ Unknown 5 ☐ Other (specify) detached ☐Yes 2 ☐No Ö 9 Unknown 4 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð sign Pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s 2 No 1 ☐ Yes of Vital Physiclan: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 NInpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Division Hospital or Attending 5 Pending investigation 1 🖪 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Medical Doctor RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bryvier Medical Center, 4940 Eastern Ave Baltimon, MD 21224 \mathcal{C} Chronister Justin 31. Date filed (Month, Day, Year) Registrar's Signature State 21 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Harry Month Лау Year Martin /Medical 2:40 PM 2017 16 2008 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 215-32-2646 Days Hours **Director** 74 APRIL 24,1984 FLORIDA Usual Residence of Decedent Shov 10c. City, Town or Location 10d. Inside City Limits r 28a-f s notified Director MD N/A X Yes 2 □ No BALTIMORE 10e. Street and Number ö 10f. Zip-Code 10g. Citizen of What Country? must be Funeral | 23a 155 S. GRUNDY STREET 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 þ 1 ☐ Yes 2 📉 No 3 ☐ Widowed 4 X Divorced "natural", Specify: WHITE Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done di life. DO NOT use retired) during most of working Elementary/Secondary (0-12) is marked other than College (1-4 or 5+) DRIVER CAB CO event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental H N/A မ MARTIN Pages 1 and 2 should N/A 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health HARRY MARTIN, JR. / SON 2001 BEAR RIDGE ROAD, APT. 3, DUNDALK, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of I
Important: If Ite
any Injury or of Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 7/18/08 BALTIMORE, MARYLAND 21. Signature of Euroral Service Licensee LILLY & ZEILER INC. FUNERAL HOME EASTERN AVENUE, BALTIMORE, MD 1901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21231 Approximate Interval Between Immediate Cause (Final **Physician** Onset and Death disease or condition Pheomonia /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (oras a consequence of): carcinoma Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the SS use IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Live birth 2 Fetal death 3 - Ectopic pregnancy Pregnant at time of death Month 1 ☐ Yes 2 ☐ No 5 Other (specify) Dav Year the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? page 2 should be Completed 1 Tes 2 No 3 Probably 4 Unknown peen hasr 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 2 X No 2 No 1 Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death Certification: 28b. Time of 28c. Injury at Work? Director: After 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of the Hospital hours 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Vonisle MD RES-000 July 16, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pamela Damisse Johns Hopkins Hospital 600 North Wolfe St, Baltimore, MD, 21287 39. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) 2. Date of Death July 15 **Physician** 2008 Ly Thi Mischler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months 1 □ M 2 💢 F 60 424-94-7599 70 Director February 14, 1938 Vietnam Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Expositiver must be indiffed at 10a. State 10b. County 10c. City, Town or Location Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1023 Southern Night Lane 20879 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 ∏ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Asian ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own_Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Not Available Luong Thi Phan ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health
Important: If item 27 i
any Injury or other tra Frederick Mischler / Husband 1023 Southern Night Lane, Gaithersburg, Maryland 20879 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State August 22, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Arlington, Virginia 22. Name and Address of Facility Robert A. Bethesda - Chevy Chase Inc. Bethesda, Maryland 20814-3501 Pumphrey Funeral Home 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee John J. Parm M01360 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pertorate Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' of Vital 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 1 → Natural 2 → Accident 5 ☐ Pending investigation 1 □Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Amend #7, perFh g881 7/25/08 TT
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2138

10d. Inside City Limits 1X Yes 2 □ No

Approximate Interval Between Onset and Death

Day

July 16, 200 8

Olvey Haryland 2083

Year

DHMH 17 Rev 1/2001

Registrar

lullacer

A.F. Woolenavel 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of eath (Item 23a) (Type, Print)

341/0 Olanduscod C

D24190

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

			For State Registrar	State of N	/aryland / D	epartmer <i>Certificat</i>			/lental Hyg	giene Reg. No 2	008	23347
			1. Decedent's Name (First, Middle,	Last)					2. Date of Dea		Year	3. Time of Death
	Physicia /Medic		Elean Margar	et McKee					JUL			8 Ø1:27F ^M
	Examin	er	4a. Facility Name (If not institution,	-		1 -	Town, or	Location of Death		4c. Co	ounty of Deat	h
			Saint Josep 5. Social Security Number 6		Age (In yrs. last birti		r 1 Year	TOWS		h		timore hplace (State or Foreign
	Funeral Director		215-18-2817	1 M 2 M F		rs. Months		Hours Min.	8. Date of Birt (Month, Da 01-13-1	922	J. Silv	aryland
			Usual Residence of Decedent									•
	show	_	10a. State 10b. County		10c. City, Town							10d. Inside City Limits
	8a-f	Director	•	ltimore		Parkv		<u> </u>				1 ☐ Yes 2 📉 No
	ours after death with the Marylan ral", or items 23a or 28a-f show Examiner must be routified at	늅	10e. Street and Number			10f. Zip				10g. Citizer	n of What Co	
	ns 23	Funeral	9631 Mason Avenu	e 12. Was Deceder	nt Ever in U.S.	13. Was Dece		21234 lispanic Origin? (Sr	ecify Yes or No	- 14.	U.S.	
9	or iter		1 ☐ Never Married 2 ☐ Marrie	Armed Forces d 1 ☐ Yes 2 🔀	?			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White	
903	ral", c	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	3:	1 □ Yes	2 KN NO	Specify:		Sp	pecify:	White
5-(72 hours "natural", ofical Exa	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Usu (Give kind of wo	ork done o	during most of work	ing	16b. Kind	of Business/	Industry
7	withir ene. than	g E	Elementary/Secondary (0-12)	College (1-4o	r 5+)	`life. DO NOT u Artis		1)		Comm	norcia	l Business
d 2	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, I've Medical Examiner inner be realthed at	Be Co	17. Father's Name (First, Middle, La	L		/// CIS	1	18. Mother's Nam	e (First, Middle,			i business
<u>la</u> n	Ald be fental rked of tic ev	To B	William Charles	Rider				Mary M	argaret	Ruppe	el	
Maryland 21215-0036	shou and N s mai		19a. Informant's Name/Relationshi	p (Type. Print)	19b.	Mailing Address	s (Street	and Number or Ru	ral Route Numbe	er, City or T	own, State, 2	Zip Code)
Σ,	and 2 ealth n 27 i		Dolores McKee -	Daughter				n Ayenue	Balt			land 21234
ore	jes1 tofH ifiter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	B ☐ Removal from Stat	20b. Place of cemeters	Disposition (Nat y, crematory or o	me of other plac	e)	Date	20c. Loca	tion - City or	Town, State
altimore,	t. Pag tmen tant: ijury		4 □ Donation 5 □ Other (Spe	ecify)	Gardens			Cem. 07/2		Balti	more,	Maryland
Baj	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		21. Signature of Funeral Service in	censee		22. Name a		ss of Facility Ruck, I			arford	
			23a. Part 1. Enter the disease, or o	omplications that cause	ed the death. Do n						Te, M	aryland 21214 Approximate
	Physician		shock, or heart failure. List o Immediate Cause (Final	nly one cause on each	line.	of office the mod	ac or ayır	ig, suom as cardiac	or respiratory a	1031,		Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)		RAL EFFL as a consequence of							
	Examiner		O		STIVE H	•	AIL	URE				
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Mg.	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· DILAI	ED CARD	TOMORE	THY					
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		edical)}:	d								
Box (nding	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon		_				230	d. Date of del	liverv
m.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 ☐ Pregnan	n 2 ☐ Fetal death t at time of death	3 ☐ Ectopic 5 ☐ Other (s		у			Month	Day Year
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a	iclan: The certificate ector, pag								1 🗆 Yes	rmed? 2 No	death? 1 ☐ Yes	2 □ No
Zi X	siclar certif rectou	Be	25. Was case referred to medical examiner?	Hospital: 🔏			OA Oth	26. Place of Dea				
ō	Physer this eral di	<u>ب</u> ا	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpa		tpatient 3 Do	OA 28c. Injur Worl	TE Haroling 71	ome 5 Resi			ecify)
<u>.</u>	nding ath. r: Afte e fune	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		Day, Year) Ir	njury M		kí? Yes 2 ∐No		, ,		
Division of	Atte	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be 28e. Place of l	njury - At home, far etc. <i>(Specify)</i>	m, street, factor	y, office		28f. Location (: City or Tox	Street and I	Number or R	ural Route Number,
Ö	tal or rs afte al Dir led in	Cert	4 E Nomicide	building,	etc. (Opecny)				City of Tot	wii, State)		
:	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		Physician: To the be xaminer: On the basis and manner	of examination and							
:	Vithin To the comp	Me	29b. Signature and title of certifier	1-0	MN	29	c. Licens	e number		29d. Date:	gned (Mon	h, Day, Year)
	10		1 (moll	4 tow.	Mil.		D240	234		7	1181	08
	1		30. Name and address of person w	ho completed cause o	f death (Item 23a) (ated feese "T"	ton boof 2		- (, , ,	
			TIMOTHY LOW.	M.D. 760	u OSLER	PRIVE	TO	WSON, M	ARYLAN	0 213	204	
	Sta Registr		31. Date filed (Month, Day, Year)	1008 Regi	strar's Signature	garde	•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Month Year 3:33 PM 2008 Betty E. McNeill /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHARLES CIVISTA LA PLATA MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) 09-09-1938 6. Sex 7. Age (In yrs. last birthday) 69 Yrs. **Funeral** 1 M 2 F Months Days Hours Wash.D.C. 579-46-0715 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at PG Clinton X∏Yes 2∐No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20735 8500 Mike Shapiro Dr. Apt 216 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 □Yes 2 ☐No Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Private Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. Courthouse Clerk 12th Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, It once. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Thomas Goings Bessie Sexton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4238 Suitland Rd.#203 Suitland, MD 20746 19a. Informant's Name/Relationship (Type. Print) Jacqueline Gomez/Daughter 20b. Place of Disposition (Name of Riverdate, MD 7-19-2008 Riverdate, MD 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral III 21 In gnature of Funeral Service Licensee 108 W. North Ave.Baltimore, MD 21201 Lonald 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** 000m disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner GNCE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): physician Physician/Medical the attending p for use as t . nse s IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 🗆 Ectopic pregnancy 5 Other (specify) P.0. 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page performe certificate 1 □Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. 08 11345 PEMBROOKE WALDORY n who completed cause of death (Item 23a) (Type, Print) SOUARE Name and address of pers

State Registrar TRORLE

Year) 2008

31. Date filed (Month, Day, JUL 2 1

MCNEI

CM O

32. Registrar's Signature

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08-05121

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 23349

Timothy Alan Nalep		Sta For State	ate of Mary	/land /		ment of icate of		and	Menta	al Hyg	giene		200	18 2334
	R	egistrar . Decedent's Name (First, Middle	1 oot)		Certin		Dealii			2	. Date of De	Reg. No		3. Time of Death
Physician/ Medical Examiner	Timothy Alan Nalepa Month Day Year July 3, 2008									Year	2027 hrs			
į .	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Coun									c. County of Deatl				
	3448 Old Crown Drive Pasadena 5. Social Security Number 1 I 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye									,		- 1	Anne Arundel	
Funeral	5	Social Security Numbernit				birthday)	If Under Months			Min.			I Forei	rthplace (State or unit- gn buntry New York
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any	_	Jsual Residence of Decedent 0a. State 10b. County		ſ	10c. City, To	wn or Location	on	·						10d. Inside City Limits
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the Maryland 1 or 28a-f show	1	0e. Street and Number		1			10f. Zip C					10g. Ci	tizen of What Cou	intry?
the Jain or Dir		3448 Old Crown	Drive					1122					USA	
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or deat			1 Ye	s 2	X No		Yes 2X	Nio	enecify:				Specify: W	hite
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of Vital Records, ig Physician: The law requir wher this certificate has been s meral director, page 2 should no To Re Complete.	2 L	1 Yes 2 No 27. Manner of Death	1			R/Outpatient		•	ry at Work		g Home 5		idence 6 🗸 Ott	ier: Scene
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Division o spital or Attending hours after death. meral Director: Aft y filled in by the fune Centification:			Id not be ermined (Spe		,,		•				or Tow	n, State)	
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	1	one) 2 Medical Exa		asis of exa ner stated.	mination and	I/or investiga	tion, in my	opinion	, death oc	curred a	t the time, d		place, and due to	
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		 Name and address of persor Donna M. Vincenti, M 			death (Item 2 cal Exami		1 Penn ⁹	Street	Baltim	ore M	D 21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend #8 perFh State of Maryland / Department of Health and Mental Hygiene 2 1 8 State of Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Albert Nelson 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimure City Cheneral 5. Social Security Number Hispital 8. Date of Birth 10/5/1942 Sirthplace (State or Foreign (Month, Day, Year) . Age (In yrs. last birthday) **Funeral** 1 M 2□F Months Hours Yrs. South carolina Director 251-66-3140 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pall Mal USA 2121 4601 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 2 □ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕶 No Specify: Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Mangger 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sco Nelson ames Janie Ne |500 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) fulton Aut, Baltimore, Mp. Nelson Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 □Removal from State 7/17/08 Cenetery Lansdowne, MO. mount 2001 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Parker Funeral Home, P.A. 3512 Frederick Rd.
Baltimuse, Maryland 21229 21. Signature of Funeral Service Licensee Patrew Blacketa M01450 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MAMZANON /Medical Due to (or a a consequence of): Examiner Lordiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ in the past 12 months? Month Year 1 Yes 2 No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performe certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated.

Division or Vital Records, P.O. Box 68760,

Registrar

JUL 1 9 2008 DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ny

30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

M.D

32. Registrar's Signature

29c. License number

Go Maryand General Hospita

29d. Date signed (Month, Day, Year)

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*	mine		4a. Facility Name (If not institution, give street and r				r Location of Death		4c. County		
Fune	ral	-	FRANKLIN Square Hosp 5. Social Security Number 6. Sex	7. Age (In yrs.		day) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th		place (State or Foreign
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land ow			Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town	or Location					10d. Inside City Limits
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ile, INTALYIGHTU ZIZIO-UUJO s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event.			Saundra Lee Jordan (Da	ughter)	1	8 Middlebor			•		
parmit. Pages 1 and 2 Department of Health 8 Important: If Item 27 is any Injury or other tra			20a. Method of Disposition 1	20b.	Place of E cemetery	Disposition (Name of crematory or other place	ce) 7	Date / 22	20c. Location -	City or To	own, State
permit. Pages 1 Department of H Important: If Ite any Injury or ot		t	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		rela	nd Memorial 22. Name and Addre		008	Baltimo	re,	Maryland
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To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	legipal	3	29a. Certifier (Check only one) 1 CertifyIng Physician: To the 2 Medical Examiner: On the	basis of examina	owledge, ation and/	death occurred at the tir or investigation, in my o	me, date and place, pinion, death occur	and due to the ed at the time,	cause(s) and m date and place,	anner as	stated. to the cause(s)
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9	2	- 1	30. Name and address of person who completed co	se of death (Iter	n 23a) (T	ype, Print)		172			
	State		DR Kambun & Auyeun 31. Date filed (Month, Day, Year)	G 40 Registrar's Signa	OO ature	FRANKLIN S	oquare	UK (salto 1	na	21237
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item#8, perFH, G881, 7/21/08, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** PHAIR 11:20 QM CORNEZIA X 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOSPITAL CCU GOED BALTINORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | Hours | Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Yeal 910 Months 1 M & F 213326076 98 Casolina Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State "natural", or items 23a or 28a-f show edical Examiner must be notified at Y Yes 2 No Director MD BA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1216 Winston Ave 21239 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Black 3X Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
10th grade College (1-4or 5+) Housekeeping YMCA 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Dalton McCloud Bessie Spain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Burnette-Daughter 1216 Winston ave, Baltimore, Md altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 7/26/08 Woodlawn, Md 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/h West 21. Sig of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 221215 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. shock, or healt allure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Septic Shock Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner phes Lobe Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transi Dementia Advanced Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetai death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an , page 2 s certificate has autopsy 1□ Yes 2□No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 Yes € 10 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Injury Natural М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 RESOOO Resident M.D 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Battimose, Md - 21239 Caroline D'Souza, 5601 , Loch Raven Blud 32. gistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 4RSON 2008 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WESTOVER ASTERN CORRECTIONAL SOMERSET 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day **Funeral** 1 M 2 ☐ F Months Days Hours Min. 214-48-5796 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

and: If item 27 is marked other than "natural", or items 23a or 28a-f show and if item 27 is marked other than "natural", or hiems 23a or 28a-f show any or other traumatic event, It. M. Acical Eventhal. 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State ral", or items 23a or 28a-f show Examinar must be notified at Director 1 ☐ Yes 2√ No Somerset Westover 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 30420 Revels Neck Road 21890 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X□Yes 2□No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: White Specify. þ 3 Widowed 4 Divorced Completed unk unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jack Mark Pearson Alma Marion Oliver ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Rebecca Ann court Millersville, MD 21108 Diane Pearson/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Page Department c Important: if any Injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in state Three of Funeral Service An Thony 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Pleasant Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** FAILURE disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, fan, Laure Limit Incause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 N/0 3 Probably 4 Unknown Be Completed 1 ☐ Yes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify PRIS 0 A 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 24 hours af 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) 29c. License number MJ30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) D 31. Date filed (Month, Day, Year) . Registrar's Si State 2 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day July 17, 2008 9:23AM Betty R. Phillips 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda If Under 24 Hrs Montgomery

9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex 1 □ M 2 🗓 F Months Days Hours Min. 84 477-18-7395 August12,1923 Minnesota Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 X No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3710 Curtis Court 20815 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give Year or Dates: WIJT T Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Esther Olson Harvey Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Midland Road, Silver Spring, Maryland 20904 Joan Mulligan/Executrix 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium Inc. July 2008 4 ☐ Donation 5 ☐ Other (Specify) 18, Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M00335 Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia disease or condition resulting in death) Due to (or as a consequence of): Urinary Tract Infection Sequentially list conditions, if any leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 1∐Yes 2∭ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be

cate has been signed by the attending physiclan and page 2 should be detached for use as the burial-transl P.O. Box 68760, law requires that the death Records, certificate has Division of Vital funeral director, Phyllis, Bet After this or Attending Patter death. filled in by the

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Pages 1 and 2 should be filed within 72 hours after

Is marked other than

Department of Health ar Important: If Item 27 Is any injury or other trau once.

Physician

/Medical

Examiner

altimore, Maryland 21215-0036

To the Hospital or within 24 hours at To the Funeral D completely

State Registrar 29b. Signatur

determined

29c. License number

1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, Maryland 20814 Nathsha Haag, M.D.

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29a, Certifier



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 23355 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Day 2008 July 19, 10:59 A M Warren H. Perry 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days Hours Min 577-22-7126 87 Dec. 31, 1920 Maryland Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 803 Crothers Lane 20852 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 □ No 1937— 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No White Specify 1964 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) International Elementary/Secondary (0-12) College (1-4or 5+) Pressman Business Machines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edmund Perry Nora Norman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise G. Perry/Wife 803 Crothers Lane, Rockville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 25, Smyrna U.M.C. Cemetery Sheppards, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. M01173 | 300 W. Montgomery Avenue, Rockvil

23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. M01173 300 W. Montgomery Avenue, Rockville, Maryland 20850 Approximate Interval Between Onset and Death Immediate Cause (Final metastatic Won Small Cell Cancer L 2 YRS GHOWTHS disease or condition resulting in death) Due to (or as a consequence of): Bone me tas to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗀 Ectopic pregnancy Month Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

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attending physician for use as the burla

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To the Funeral Director: A

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Department of Health Important: If item 27 any injury or other to once.

Physician

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Funeral

Director

d other than "natural", or items 23a or 28a-1 show event, the Medical Examination to motified at

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Pages 1

72 hours after

Baltimore, Maryland 21215-0036

/Medical

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Funeral

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Be Completed

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Examiner

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Certification: To

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

27. Manner of Death 5 Pending investigation

determined

28a. Date of Injury (Month, Day, Year) 6 Could not be

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Suite 410

29b. Signature and title of certifier

D0059244

7-19-08

41805 OH ACESHTSB

30. Name and address of person who compute terms of death (Item 23a) (Type, Print) Giselle Mery, M.D. WEST

4416 ENST 31. Date filed (Month, Day, Year)

32 Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

HIGHWAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

08-05416 Joan Rustin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008	2335
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		1- For State Registrar		Cei	rtificate o		ina monta	rrygione	Reg. No.	200	0 2333							
Physici	an/	1. Decedent's Name (First, Midd	le,Last)					2. Date of D		Year	3. Time of Death							
dical Exami	ner	Joan Rusti		 				July 14,	2008		1605 hrs							
		4a. Facility Name (if not institution 400 Millington Avenue	_	mber)		4b. City, Town, Baltimore	or Location of D	eath	40.	. County of Death	1							
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs, I	ast birthday)	If Under 1 Y		4Hrs. 8 Date of	Birth (MM/I	DD/YYYY) 9. Bir	tholace (State or							
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation	_	oil Oldic	crematory or ot			= /3.0 /0.0										
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21215-0036 DOROTHV Saltimore, Maryland

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Division or Vital Records,

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1. Decedent's Name (First, Middle, Last)

Physician

RANKIN 5:00 P.M OROTHY JULY 14,2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner REISTERSTOWN BALTIMORE APT. 216 300 CANTATA COURT If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 X F 216-18-6540 Director FEBRUARY 2, 1924 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits If Item 27 Is marked other than "natural", or Items 23a or 28a I show or other traumatic event, the Medi al Examiner must be notified at REISTERSTOWN BALTIMORE 1 ☐ Yes 2 ☑ No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 CANTATA COURT Q1136 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) IQTH GRADE FEDERAL GOVERNMENT COMMODITY ANALYST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MOULTON GEORGE MABEI DECOURSEY ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAUGHTER) Important: If Item 27 any Injury or other tra 2117 LAWNWOOD CIRCLE, GWYNN ORK, MD21201 DIANNE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State CREMATORY 107-17-2008 BALTIMURE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) METRO 22. Name and Address of Facility
505EPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licenses ullans 2140 N. FULTON AVE, BACTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PULMONARY HYPERTENSION **Physician** /Medical Due to (or as a consequence of): Examiner FIBRILLATION ATRIAL associative list, over ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE nse i 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SCHIZOPHRENIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed? res 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2[**Y** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28h Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation spital or Attendil ours after death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 Medical Exam 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JULY 16, 2008 Nolters 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 LIBERTY RD., RANDHUSTOWN, MD 21133 S. WALTERS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.2 0 8

2. Date of Death

Month

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 4c per doc 98817-21-08 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 22:05 M **Physician** George Jul 17 Schopt 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. Birtifplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) PENNSYLUANIA 1 MM 2 □ F Months Days Hours 184-62-0258 Usual Residence of Decedent AN 19 **Director** 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Directo ALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3464 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No MARINGS 14. Race - American Indian, 11. Marital Status 1 Yes 2 No MARINES If Yes, Give Year or Dates: 1995 2005 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ADVANCE Elementary/Secondary (0-12) College (1-4or 5+) AUTO 1 ANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 10 ၉ Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tro Mother OMENA 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 ⅓ Burial 2 ☐ Cremation 3 ☑ Removal from State KOS14N 4 □ Donation 5 □ Other (Specify) 08 JR. FUNCRAL 21. Signature of Funeral Service Licen 10 OSEPH St BAIL Kar ounino 26 Contains Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres y one cause on each line. Part 1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Due to Fall **Physician** THE HEALTH LE PROPERTY BET WELL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 ☐ Yes 2 📈 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 K⊈Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 5 Pending investigation Fall between overlusses 1 □Yes 2 🗖 No 18:00 17,208 2 Accident July 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Highway 560 BIK 5 Bound Rt 83

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a

To the Funeral C

completely filled 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie. 0 D0066316 July 17, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Brevard MD 225. Greene St Baltimore, MD 21201 SIDNEY 32 egistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year MARY Scels1 8:50 A.M Tury 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAltimore 1AMS Hospice IIMONIUM If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 X F 213-26-8227 Director 4-13-Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10h. Count 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f shov dical Examiner must be notified at 5 DALLOWS 1 ☐ Yes 2 No Directo MAY/AND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.SA by Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: 3 Widowed 4 □ Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Highland town Market H.B.A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If It any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HT OF JESUS CAN BAHIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 7-23-08 21. Signature of Funeral Service Licensee walkling 23a. Part1. Enter the direas , or complications that caused the death. Do not enter the mode of dying, such as carefac or respiratory arrest shock, or heart failure. List only one cau ie on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NOV Smal Carcinomo months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical ası IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. I detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2DNo 3 Probably 4 Unknown 1 🗌 Yes plnods been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2★ No 24a. Was an has autopsy perform this certificate 2. No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2€ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item \$3a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

ERNESTINE WRIGHT, M.S.

JUL 2 1 2008

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY ROAD

32. Registrar's Signature

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMIND TIFM#23apt1 C881 / 21/08 State of Marviand Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Pay 14 2008 **Physician** 8:45 E. SMALLEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel 7218 Crown Road Glen Burnie If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) NJ 8. Date of Birth (Month, Day,) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 F 90 343-48-8692 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Experiment must be notified at Anne Arundel 1 ☐ Yes 2 No MD Glen Burnie Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21060 USA 7218 Crown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2XXNo Specify: Specify: white 2 3 X Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Methodist Home Elementary/Secondary (0-12) College (1-4or 5+) Supervisor of Chicago 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linthicum Annie Morris Potter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21060 Mr. Ronald Smalley/son 7218 Crown Road Glen Burnie 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 7/17/2008 Catonsville MD Metro Crematory 4 □ Donation 5 □ Other (Specify) f pera Service 21. Signifure 22. Name and Address of Facility Kirkley Ruddick Funeral Home PA M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year **Physician** resulting in death) /Medical Due to or as a consequence of): Examiner 2 years Weight Loss Sequentially list conditions, Due to lor as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 2 years Porphyria Division of Vital Records, P.O. Box 68760, 2 years Physician/Medical Dysphagia IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 15/08 0033296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Keld RD Glen Burne MD 21061

State Registrar EP

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23362 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1230A Month **Physician** 2008 lichele /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NA Baltimore Sheldon Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
 Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Vary and Months Days Hours 1 □ M 2 🗗 F 219-82-0853 -31-66 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination roust be invitined at 1 √Yes 2 No Director Itimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21206 heldon Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Black Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "na any injury or other traumatic event Nortional Security Elementary/Secondary (0-12) College (1-4or 5+) stem HnalysT 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Stephens Sampson Mae sieorge ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sheldon Avenue Baltimore MD 21206 Ma М. Sampson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore sorraine Park Cem. 07-25-08 4 ☐ Donation \ 5 ☐ Other (Specify) 40 North Fulton Avenue MD 22. Name and Address of Facility 21. Signature of Fureral Services Baltimoro Brown Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jurs 2 mo **Physician** Breast disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar Day in the past 12 months? 1 □Yes 2 □ No 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.
e Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier fying Physician: 76 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Me ical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and ti 29c. License number 21,2008 d was of person who completed cause of death (Item 23a) (Type, Print) 30. Name al Edelven, 22 san 32 degistrar's Signature Greene St, Baltmure, MD , 225

DHMH 17 Rev 1/2001

State

Registrar

2 Day, Year)

2008

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2008 July 16, 622 PM **Physician** Snyder, III Edward Henry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 1729 Winans Avenue Halethorpe 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 🖫 M 2 🗆 F July 16, 1947 Director 212-54-7736 61 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b County show d 2 should be filed within 72 hours after death with the Marylar lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exyminer must be notified at 1 ☐ Yes 2 Tx No Director Maryland Baltimore Halethorpe 10g. Citizen of What Country? 10e, Street and Number 10f, Zip Code 21227 USA 1729 Winans Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Technician Northrop Grumman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev McKitrick Edward Snyder, Jr. Laura ပ Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda L. Snyder (Wife) 1729 Winans Avenue, Halethorpe, MD 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 7/21/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia yea **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner arkinson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ctopic pregnancy 5 ☐ Other (specify) P.O. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been: 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: safter death.
I Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE #300 DALTIMORE 31. Date filed (Month, Day, 32. Registrar's Signature Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23364 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day July 13, 2008 0230 hrs `বা Examiner 2M 14t 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** oreign Country) Months Hours Director 1 2 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location any 10b. County Yes 2 No 28a-f show Director 10g. Citizen of What Country? 10f. Zip Code , or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Was Decedent Ever in U. Funeral the Medical Examiner must be White, etc. Armed Forces Never Married Yes Yes 2 No specify: If Yes, Give Year Widowed Divorced 3 "natural", 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) it. Pages 1 and 2 should be filed within 72 hou timent of Health and Mental Hygiene. during most of working life. DO NOT use retired) Completed College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname Be (Street and Number or Rural Route Number, City or 19b. Mailing Address 20b. Baltimore, 2 Cremation 3 Removal from State Important: injury or oth Donation 5 Other Specify: Approximate Interval Between Onset and the disease, or complications that caused the death. Do not enter the mode of **Physician** failure. List only one cause on each line. **Vedical** Death a. Gunshot Wound of Chest Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner couse. Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and hysician/Medical UNPENDED AMENDED signed by the attending physician it be detached for use as the burial -Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Dav 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available has been s prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes certificate h 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical director. Division of Vital Be Other; examiner? Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA this 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Jul 13, 2008 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Subject shot Certification: 0157 hrs within 24 hours after death.

To the Funeral Director: All completely filled in by the fur Natural Yes 2 ✔ No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) 3232 Lyndale Avenue, Baltimore, MD determined (Specify) Front Porch 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 13, 2008 O.C.M.E. Drassel 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 1455 M Samerski 5 aymoud /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Med Centre N/A saltimore ONNS HODRINS 8. Date of Birth (Month, Day, Year) 1941 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1**X** M 2 □ F MARYLAND 212-40-0095 67 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State d other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at 1 X Yes 2 □ No Director BALTIMORE N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21206 4876 GREENCREST ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 No 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify Specify: ≥ WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRUCKIING DRIVER 7 is marked other traumatic event, 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ADA PEACOCK WILLIAM SAMENSKI RAYMOND ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar 999 NE 39th ST.,OAKLAND PARK,FLORIDA 33334 STEVE SAMENSKI/ SON Department of Health Important: If item 27 any Injury or other to once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State BALTIMORE, MARYLAND OAK LAWN CEMETERY 7/19/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME 21231 1901 EASTERN AVENUE, BALTIMORE, MD. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LeasiN howes **Physician** puleumothora disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner signature Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or all a consequence of : ner The law requires that the death certificate be executed Exami Due to (or as consequence of): and burial-trar Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐Yes 2 No 1 □Yes 2 DNo ospital or Attending Physician: hours after death. uneral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 24 hours a Hospital 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the l within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

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Laun

30. Name and address of per n who completed cause of death (Item 23a) (Type, Print)

Year)

1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** _Month Year AM 2008 10:15 Jul /Medical 4a. Facility Name (If not institution give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner rince Momas More Nursing Home ttsville ya reorges If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) 5. Social Security Number 6. Sex Age (In yrs last birthday) **Funeral** Months Days Hours Min. 30-38-688 1**⊠**M 2□F 2 Yrs. May 11,1936 Director ira Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ¥Yes 2 No by Funeral Director Washington 10g. Citizen of What Country? 10e. Street and Number 101. Zip Code 3009 SA 001 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If Imm 27 is merimortant if Health and Mental Important: If item 27 is merimy or other: Be L'onner Janie ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7th Street N.E. Washington, D.C. 20017 DUMMERS 3009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State /08 Pleasant Valley Memoral Park Innandale, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License hinn runeral Seruce 2605 S. Shirlington Load Arlington, Va 22266 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A proximate Interval Between Onset and Death Immediate Cause (Final Physician Arterios cherotic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as signed by the attending the detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2∏ No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Infanction 24a. Was an has autopsy performed? certificate 1∐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Attending 1 Matural 5 Pending investigation 1 Tyes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00185 pleted cause of death (Item 23a) (Type, Print) QueensburyRd Hyattsville MD 20281 4203 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 23367 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Frederick John Sauer 7:15 P M July 15, 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 8.16 Hornel Street

5. Social Security Number 6. Sex Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₺ M 2□ F Months Days Hours Min. Yrs. Director Feb. 25,1946 Maryland 218**-**44**-**1965 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examinational feet religion at Director 1XXVes 2∐No Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21224 816 Hornel Street United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★★es 2 No 11. Marital Status 14. Race - American Indian. filed within 72 hours after 1 ★★es 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify \$ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Crane Operator Scrap Metal Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t and 2 should be fill Health and Mental H tem 27 is marked oth Be Frederick A. Sauer Frances H. Janiszewski traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Frederick H. Sauer 18496 North 170th Lane Surprise, AZ 85374 (Son) injury or other permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 7/19/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 32RC 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carro **Physician** rella 6 MONTY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit requires that the death certificate be exec Due to (or as a consequence of). Box 68760, attending physician Physician/Medical the as IF FEMALE: ISE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy į in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 No The certificate 2 **N**o 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 4No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the within ? To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EATTERY AVE NYBUM URTRI Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month Year 2008 8:30AM July 17, Sue Anderson Van Ness /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛚 F Months Hours Yrs **Director** 577-38-0176 83 January 14, 1925 Kansas Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ā Funeral 7108 Broxburn Drive 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 X No Specify ₽ Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ <u>John Benjamin Anderson</u> Sue Moore Palmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl Department of Heatth an Important: If item 27 is n any injury or other traun 5359 Black Oak Drive, Fairfax, Virginia 22032 Scott Van Ness/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington
National Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State September 16, 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M00335 Bethesda, Maryland 20814-3501 Arlington, Virginia 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 48 Hours disease or condition resulting in death) Acute Hemmorrachic Stroke Due to (or as a consequence of) Atherosclerotic Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami resulting in death) Last Due to (or as a consequence of) IF FEMALE:

Physician /Medical Examiner

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at

should be filed within 72 hours after and Mental Hygiene.
marked other than "natural", or ite

12 should be fii h and Mental F ' is marked ott

Maryland 21215-0036

Baltimore,

Box 68760,

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Records,

of Vital

Division

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death v

physician and the burial-transi

Physician/Medical use as t ρ ≥ Completed page 2 Certification: To

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ANo

25. Was case referred to medical

1 Yes 2 X No

27. Manner of Death

1 X Natural

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

attending s been signed by the s has certificate or Attending Physician: this After thi funeral death. within 24 hours after death

To the Funeral Director:
completely filled in by the f

20

Medical

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23d. Date of delivery Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy perform 1 □Yes 1 ☐ Yes 2 X No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No

Year

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

D31287

July 17, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2008

Hospital:

determined

Wisconsin Ayenue, Suite 105, Bethesda, Maryland 20814 Albert K. Lee, M.D. 31. Date filed (Month, Day, Year) Registrar's Signatur

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 & 17, perFH g881 7/25/08 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Ju1y 21, 2008 3:30 A. Margaret Wray /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Marley Neck Health & Rehab. Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 911 Days 1 □ M 2 🔀 Director 94 June 4, 1914 New York 050-01 9113 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States Funeral 726 Snowden Lane 21061 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ð 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Candler H.C. Bohack Egg. Co. permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If item 27 is marked other any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Baldeweg** ည Rudolph Baldewig <u> Elizabeth (Unknown)</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 726 Snowden Lane, Glen Burnie, MD 21061 Eileen Silvers / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 21, 2008 1 ☐ Burial 2 ☑ Cremation 3 ☐Removal from State July Catonsville, Maryland 5 ☐ Other (Specify) 4 Di onation Metro Crematory ure of Funeral Serv 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. 21. Sign! 421 Crain Hwy. SE; Glen Burnie, MD 21061 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** -araua /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ MIN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 🙀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 X Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sign vre and title of certifier D57028 7/21/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 21401 600 Ridgely Ave. #231 Annapolis, MD Aditya Chopra M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2008 Hon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** NA Hospi Hal Daltimere If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**№**M 2□F Yrs. July 23,1922 VIRGINIA 216-12-3161 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show 1 XYes 2 No ortant: If item 27 is marked other than "natural", or items 23a or 28a-f st Injury or other traumatic event, the Medical Examiner must be notified BALTIMORE Funeral Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number #316 PARK HEIGHTS AVE, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ▼Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 🔀 No Specify: <u>م</u> 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mr. LEBANON BAST. Church s 1 and 2 should be filed wi f Health and Mental Hygien tem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be JENNINGS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health ar Important: If item 27 is 1324 PENTRIDGE RD, BALTIMORE, MD 21239 (SON) WARD YRONE 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐Removal from State CARRISON FOREST VET. CON 07-23-2008 OWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 2140 N. Fulton Avenue 21217 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ictrich N. h William Joseph H. Brown Jr. Funeral Home Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer LUNG /Medical Due to (or and consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown n signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown er tension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ N 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 DUDGUSUN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK B STREET BALTIMORE, MARYLAND Greent 10 NOWTH 31. Date filed (Month, Day, 32. Pegistrar's Signature State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene rgierie Reg. No. 2008 1 - For State Registrar Certificate of Death 1. Desedent's Name (First, Middle, Last, 2. Date of Death Month **Physician** ores 2008 06:41 AM ulV /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** oital Baltimore Hos Balhmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. 65-26-19 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months 1 □ M 2 🗹 F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits State show injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director TMOIT 28a-f 10e. Street and Number 10f Zin Code 10g. Citizen of What Country ŏ 0 23a Funeral or items ? 2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 | Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify 100 Specify: 2 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pa permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many injury or other traumatic event. College (1-4or 5+) Securitu 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 10 mes 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21201 luna taos useery MO Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State landalls town Memorial 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility of Funeral Service Licenses 3 4600 LIBERT 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Exacerbation Immediate Cause (Final Asthma Physician 4 cute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ρ Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should Completed peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? /es 2 \(\overline{\text{No}}\) certificate 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ res 2 ☐ No director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral . Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 050693 2008

State Registrar 31. Date filed (Month, Day, Year)

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HOSPITAL OF BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Las	;t)	Ce.	- Inicate of t	Jeain	2. Date of Death	3. No.2008	23372 3. Time of Death					
	Physici		Lottie P. Wood	-7				July 17,	^D 2008 Year	5:12 P. M					
	/Medio Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Dea	4c. County of Dear	th						
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	or 28g	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	Lpuntry?					
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3	hour		15. Decedent's Edi	Year or Dates:	16a. Dece	dent's Usual Occupa	ition	16	b. Kind of Business/						
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7	Men Men Marke Marke	은	Hannibel Powell				Ila She								
2	d2sh thand 7.1sn traun		19a. Informant's Name/Relationship (7) Kathryn W. Chamber					Rural Route Number, (, N. Bethe							
נֿע	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eventies.		20a. Method of Disposition		Db. Place of Dispo	sition (Name of			c. Location - City or						
	permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cren covidence I	natory`or other place Inited	· Aug	ust 2,	-						
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			23a. Part 1. Enter the disease, or comp	lications that caused the c						Approximate Interval Between					
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	/Medical		resulting in death)	Due to (or as a con											
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	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d											
	rtifica ng ph as th	Medi	IE EEGAN E.												
5	eath certific attending p for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I		Ectopic pregnancy			23d. Date of del						
	the ar	sici	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown		Other (specify)			Month	Day Year					
	that the de	Phy	Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	iderlying cause give	n in Part I	23e Did tobar	co use contribute to	the cause of death?					
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		a)	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2X eath (Check only one)]No 1 □Yes	2 □ No					
	nis ce direc	10 B	examiner? 1 ☐ Yes 2 🖾 No	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatien	t 3 DOA Othe			e 6 🖾 Other (Spec	Daughter's Cify) Residence					
: :	Attending Proystclan: It death. ector: After this certific by the funeral director, I	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year	28b. Time of Injury	28c. Injury Work	at	28d. Describe how							
	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				es 2□No	7-7-13							
	or Au after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, stre ec <i>ify)</i>	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,					
29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										to the cause(s)					
i i	Vithir Comp	Me	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Month	n, Day, Year)					
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7	12		30. Name and address of person who co							,					
			Kelly Cowen, M.D.			oad, #111	, Rockv	ille, Mary	Land 2085	4					
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year 2335 PM DORCAS WALKER JULY 09 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD COUNTY GENERAL HOSPITA COLUMBIA HOWARD 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Months Days Hours Min. Director Mar 2, 1934 So. Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Maryland **Baltimore City** Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4008 Colborne Road 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No ò Specify. Specify: 3 Widowed 4 Divorced Black Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Supermarket Cashier 12 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wesley Simmons Christine Simmons ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If Item 27 Is or other trau Roosevelt Walker 4008 Colborne Road Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department o Important: If any injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 07/16/08 Baltimore, Md. Loudon Park Cemetery 21. Signuting Funeral Senfice 🗗 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 23a. Part . Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) espirato. /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last lumona Examiner death certificate be executed and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown been Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy b<u>ri</u> athor 2 ST 1∐ Yes 2**X**No 25 Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No Inpatient P 2 ER/Outpatient 3 DOA this 5 Residence 6 ☐Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1-Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature

31. Date filed (Month, Day,

and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Men Ch

32. Registrar's Signature

Cotur

D 36845

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 13 **Physician** RONALD **JAMES** ARNOLD 2008 3:30 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9990 TIMBERNECK PLACE CHARLES FAULKNER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. SEP. 19, 1959 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☑ M 2 🗆 F PENNSYLVANIA 408-13-2002 48 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a, State 10b. County 1 ☐ Yes 🍇 ☐ No Director MD CHARLES FAULKNER 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number items 23a or 2 iner must be n 9990 TIMBERNECK PLACE U. S. A. 20632 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. torces: tortonices: tortonices: Tyes, Give Year or Dates! 65 – 185 1 Never Married 2KD arried ō 1 ☐ Yes 2 ☑ No 3altimore, Maryland 21215-0036 Specify: ģ WHITE 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) MASTER CHIEF U. S. NAVY 27 is marked other traumatic event, t other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLAYTON ARNOLD RITA MARIA FABIANI ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) TIMBERNECK PL. FAULKNER, MD 20632 ion (Name of Date 20c. Location - City or Town, State DOROTHY L. ARNOLD/SPOUSE 9990 Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition OCTOBER 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If It any injury or o once. 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NAT.CEM. 22,2008 ARLINGTON, VA 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service M00641 5635 WASHINGTON AVE., LA PLATA, MD20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) × MLONTUS IOBLASTUMA Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician at the burial Physician/Medical as attending IF FEMALE: ase 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No þ 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? res 2 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760, Director: hours after n 24 hours aft ie Funeral Di iletely filled in

Medical

(Check only one)

29a. Certifier and manner stated. 29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed, (Month, Day,

Year)

80

cause of death (Item 23a) (Type, Print) ompleted Name and address of person who

State Registrar

32. Registrar's Singature

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 July 4, Year **Physician** 10:50 P M George Edmond Barrett /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carro11 Westminster Dove House 8. Date of Birth (Month, Day, Apr 19, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Yrs Ĩ941 Maryland 219-38-2537 Director 67 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits itam 27 is marked other than "neturel", or Itams 23e or 28e-f show other traumstic event, the Modical Examiner must be notified at 1 ☐ Yes 2 X No Director Owings Mills MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21117 USA 9500 Side Brook Road Unit 403 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status African 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: American If Yes, Give Year or Dates: 1963-65 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) and Mental Hygiene. Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental! Hazel Thompson George Edmond Barrett ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 9500 Side Brook Road Unit 403 Owings Mills, MD 19a. Informant's Name/Relationship (Type, Print) Lucille Barrett/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory i 07/08/08 Beltsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to lo Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of) Physiclan/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy þ in the past 12 months?
1 Yes 2 No Month Year Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to he cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by pe 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

 1 ☐ Yes
 2 ☐ No 24a. Was an certificate has autopsy performe 1 Yes 2 Physicien: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Certification: To 1 Yes 2 ER/Outpatient 3□ DOA 6 [this er of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injun occurred To the Hospital or Attending Injury Natural 5 Pending within 24 hours after death. To the Funeral Diractor: A investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Detrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examination to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 2 Medicel Exeminat: On and completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who complete od cause of death (Item 23a) (Type, Print) Yousut Garbar 31. Date filed (Month, State Registrar JUL 0 8 2008

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

08-04851

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State of Maryland / Department of Health and Mental Hygiene Eric N. Brodus 2008 23376 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0741 hrs June 23, 2008 ¬I Examiner Eric Brodus ERIC BRODIS 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Country) D.C. NOV. 17, 1964 Director 43 578-88-6990 1 XM 2 Yrs Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 1 Y Yes 2 No WASHINGTON items 23a or 28a-f show ust be notified at once. D.C. vit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland rinnen of Health and Mental Hygiene.

or other traumovit. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 20020 1900 MINNESOTA AVE., S.E. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? 1 X Never Married 2 Married X Yes BLACK Yes 2 X No specify: Specify: Divorced If Yes, Give Year Widowed <u>م</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) pleted College (1-4 or 5+) $1 \mathrm{Yr}$ Elementary/Secondary (0-12) **PRIVATE** BARBER Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KRECEDA PAGE Be BRODIS ROBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٩ BRIGHTSEAT RD. HYATTSVILLE. MDPAGE/MOTHER KRECEDA 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State BELTSVILLE, MD CHESAPEAKE CREMATORY 7/11/08 Donation 5 Other Specify DC 20002 an ature of Funeral Service Licensee WASH CAPITOL MORTUARY 1425 MARYLAND Approximate Interva ase, or complications that caused the death/Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and cause on each line. failure. List only Death **Medical** a. Heroin intoxication Immediate Cause (Final disease _xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner eause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and X AMENDED #1,23a,27,28a-f, perME, g882 8/6/08 TT Physician/Medical X UNPENDED g physician a the burial -23d Date of delivery P.O. Box 68760. 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Day Year 3b. Was decedent pregnant in the Fetal death attending por use as the Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the ed f 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed by the detache Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 V Unknown ð Completed Records, 24b. Were autopsy findings available 24a. Was an s peen s prior to completion of cause of autopsy death? performed? certificate has 2 No ✓ Yes 2 No 1 🗸 Yes page 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital funeral director, Be Other; examiner? DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 ✓ Yes No 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Yes 2X No Natural Pending filled in by the f 6/24/08 Fnd 7:16 am FNd 24 hours after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 4300 R. St. 3 Suicide Capitol Heights, MO determined (Specify) found on sidewalk 4 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 25, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 31. Date filed (Month, Day, Year,

State

Registrar DHMH 17 Rev 1/2001

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 53 PM BELL FRANK BERNARD 2008 Ju /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAGERSTOWN WASHINGTON WASHINGTON COUNTY HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 3/28/1952 WEST VIRGINIA 1**火**□M 2□ F 56 235-84-5006 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at INMOOD 1 ☐ Yes 2 No WV BERKELEY Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 25428 87 FUJI COURT by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 □ Yes 2 □ **(**No If Yes, Give Year or Dates Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER/CONSTRUCTION RESIDENTIAL and Mental Hygies marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evonce. ELEANOR ASHBAUGH JAMES CLEVELAND BELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 87 FUJI COURT, INWOOD, WV 25428 LINDA LONG/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State PLEASANT WILEW MEMORY JULY 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MARTINSBURG, WV 4 □ Donation 5 □ Other (Specify) = 2008 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 21. Signature of Funeral Service License leoTh. 327 W. KING ST., MARTINSBURG, WV 25402 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause an each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Stage Equantially hat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ending physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 PNo To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Nnpatient မ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t Certification: Division 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide **Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year)

JUL 2 1 2008

DHMH 17 Rev 1/2001

26 Upg I Court

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla		artment of rtificate of		1	Reg. No. 20	8 23378		
	Physici /Medic		1. Decedent's Name (First, Middle, Las Stehman Harriso	,				2. Date of Dea Month	Day Ye	ar 3:02 PM		
	Examin		4a. Facility Name (If not institution, given Peninsula Regiona 5. Social Security Number 6. Social Security Num	l Medical Cen		Salis If Under 1 Year	If Under 24 Hrs	8 Date of Birt	4c. County of D Wicomi	CO Birthplace (State or Foreign		
	Director		208-26-2547	X M 2□F 96	Yrs.	Months Days	Hours Min	. (Month, Da		yn Mawr,PA.		
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits		
1	8a-fsl	Director	DE Sussex	La	urel					1 □Yes 2 XNo		
8	3a or 2	10g. Citizen of Wh										
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Evaminer must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 □ No If Yes, Give Nav			Hispanic Origin? (pan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)				
9-0	2 hour	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Tather's Name (First, Middle, Last) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dairy Farming 18. Mother's Name (First, Middle, Maiden Surname)										
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pu	be filed Ital Hyg Id othe event,											
Maryland	should nd Mer marke imatic	Stehman Brubaker Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,										
Ž,	is 1 and 2 soft Health a item 27 is		Ida Mae Davis	(Friend)	32828	Bi-Stat	e Blvd.		Delaware			
altimore,	ages 1 nt of H :: If iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Hemovai irom State		sition (Name of matory or other pla	i	Date	20c. Location - City			
턡	mit. Pa partme sortani r injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licenter)			iens Park 2. Name and Addr		7, 2008		Delaware st Street		
ä	permi Depa Impo any ir		Hooly Short-	Hannigan						1, De. 19956		
-	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	4.3	th. Do not ent		ing, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death		
	ficate be executed Thysician and the buriat-fransit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):		falmor Alation	n	Years Years			
	To the Hospital or Attending Physician: The law requires that the death certific thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as seen as the complete of the funeral director.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	ancy al death 3	☐ Ectopic pregnan ☐ Other <i>(specify)</i> _			23d. Date of Month			
rds, P.	quires that n signed by ald be deta	by	Part II. Other significant conditions co	ontributing to death but not re	sulting in the ur	nderlying cause gi	ven in Part I.			e to the cause of death? Probably 4 Unknown		
Division of Vital Records,	:: The law requir icate has been s ; page 2 should	Completed						24a. Was autop perfo 1 □ Yes	prior prior deat	e autopsy findings available to completion of cause of h? Yes 2 🏻 No		
<u> </u>	/sician s certif firector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ER/Outpatier	ot 3 DOA Ot		eath (Check only o	<i>ne)</i> dence 6	Pagaiful		
on of	nding Physician: The i ith. :: After this certificate ha e funeral director, page	ation: T	27. Manne Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Inju Wo			now injury occurred			
The property of the property										r Rural Route Number,		
	Hosp 24 hou Funet stely fil	Medical		ysician: To the best of my kn iner: On the basis of examin and manner stated.								
	Vithin Comply	Me	29b. Signature and title of certifier			29c. Licen		-	29d. Date signed (M	onth, Day, Year)		
	O SIL		termo	& france	nun		004121	(7/02/08	•		
,	84		30. Name and address of person who of Fernando Acle 1008	completed cause of death (Ite	m 23a) (Type,	Print)	d. 21801					
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature 4004	ري						

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the Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director Funeral Completed by Be Physician /Medical Examiner Examiner Physician: The law requires that the death certificate be executed physician and s the burial-trans Physician/Medical attending p IF FEMALE: as been signed by the Jas page Hospital or Attending n 24 hours after death.
he Funeral Director: Af noletely filled in by the fu Medic within 2 29b. Signature and title of certifier

1 - For State Registrar

10a. State

MD

Physician

Examiner

Funeral

Director

/Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8:58 A 2008 Arthur Joseph Binette JUV 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death CIVISTA CHARLES MEDICAL CENTER PLATP If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 5, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 15 M 2 F 020-20-2075 79 Rhode Island Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 □ No Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Carol's Place, Apt. 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖁 No White If Yes, Give Year or Dates: Specify: Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Food Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jim Binette/Son 11615 Amalya Place, La Plata, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/28/2008 | Arlington, VA Arlington National 21. Signature Officeral Service License 22. Name and Address of Facility M01458 AREHART-ECHOLS FUNERAL HOME, P.A. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart days. Due to (or as a consequence of) Kidney failure weeks Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last months Stage Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. /n ie

ed D	peripheral 1	rascular disease, (AD,	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknow				
Complet	HTN	Diebetes Mellitus	24a. Was an autopsy performed? 1 \(\subseteq \text{vs} \) 2 \(\subseteq \text{No} \) 24b. Were autopsy findings availab prior to completion of cause of death? 1 \(\subseteq \text{vs} \) 2 \(\subseteq \text{No} \)				
9	25. Was case referred to medical	26. Place of Death (Check only one)				
0	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Residence 6 Other (Specify)				
ation:	27. Manner of Death 12 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
ertific	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined						
cai		hysician: To the best of my knowledge, death occurred at the time, date and place, ar					

29c. License number

D-61614

29d. Date signed (Month, Day, Year)

Tuly 2 nd, 2008.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

R. Jindhumi

RAVINDER K. SIMOHWALLI, M.D. 6 POST OFFICE ROAD SUITE IO WALDORF, MD

31. Date filed (Month, Day, Year) JUL 07 2008

32. Redistrar's Signature

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Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

			For State	State o	of Maryland	/ Depa	rtmen	t of H	ealth a	and M		iene2 ()	08	23380
			Registrar 1. Decedent's Name (First, Middle, La.	st)			imour	00, 1	- Cairr		2. Date of Dea	th		3. Time of Death
	Physicia		Howard Wayne Bal	dwin,	Jr.						Month July	Day 4	Year 2008	11:30 A ^M
Ŷ	/Medic Examin	_	4a. Facility Name (If not institution, giv	e street and nu	ımber)		4b. City,	Town, or	Location	of Death		4c. Count		
		-	248 Old Zion Roa					North East				Cec		
	Funeral		5. Social Security Number 6. S	ex M∑M 2□F	7. Age (In yrs. las	s <i>t birthday)</i> 51 Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day	, Year)	Cour	
i.	Director		Usual Residence of Decedent			71					Jan. 6	, 1947	Penr	ısylvania
	yland now at	Ì	10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Limits
	a-fst	cto	Maryland Cecil		No	orth E	Cast							1 ☐ Yes 2X No
	ith the	Director	10e. Street and Number				10f. Zip				1	10g. Citizen of	What Cour	ntry?
	sath w		248 Old Zion Road		cedent Ever in U.S.	10.1	Non Dono		21901		oifu Voc or No.	U.S.	A ce - Americ	an Indian
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed F	orces? 2□ No						ecify Yes or No- Rican, etc.)	Bla	ack, White,	etc.
20	ursal al', or Exam	by	3 Widowed 4 Divorced	If Yes, G Year or I	ive Dates: 1966-7	72	1 ☐ Yes	2X No	Specify:			Speci	ify: Wh	nite
9500-61212	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show fent, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	dent's Usu kind of wo DO NOT u	al Occupa	ation during mos	st of worki	ng i	16b. Kind of E	Business/In	dustry
[2]	vithin ne. han " e Me	ď L	Elementary/Secondary (0-12)		(1-4or 5+)		uck I					Tran	oport	ation
7 0	illed w Hygie ther t		12 17. Father's Name (<i>First, Middle, Last</i>)		11	uck i)LI VE		er's Name	(First, Middle,			acion
au	d be ental	To Be	Howard Wayne Bal	_	Sr.						th Ann		,	
Maryland	shoul ind M ind M inari	F	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street	and Numb	er or Rura	al Route Numbe	er, City or Town	n, State, Zip	Code)
Ĕ	is 1 and 2 should be flied within 72 hours after death with the Marylan of Health and Mental Hygiene. The flem 21 is marked other than "natural", or items 23a or 28a-f show tem 21 is marked other than "natural" or items 10 to 10 tified at other traumatic event, the Medical Examiner must be notified at	li	Linda D. Baldwin	ı/Wife						Nor	th East	, MD 2	21901	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Bemoval fron	20b. Pla	ace of Dispo metery, crei	sition (Name	ne of other plac	e)	7-09	-2008	20c. Location	- City or To	own, State
Ě	. Pag tment tant: I		4 □ Donation 5 □ Other (Speci	fy)	R.T.	. Foar					.A.	Rising	Sun,	MD
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service Lice	1see	/-	F	2. Name ar	Foar	d Fun	era1	Home,	P.A.		
P-			23a. Part 1 Enter the disease, or con	plications that	caused the death.	Do not ent	ter the mod	• Que	een S ng. such as	cardiac	Risin g or respiratory ar	Sun,MI rest,	219	Approximate
0	Physician	E 19	shock, or heart failure. List only Immediate Cause (Final	one cause on	each line.		1							Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a. Due to	o (or as a conseque		M	7	2.1	, .				
5	Examiner		Cognentially list conditions	b C	arona	-4	04	0	40	La	00	2		
	pg tis	iner	Sequentially list conditions, if any, leading to it is neglect cause. Enter Underlying Cause (Disease or injury	Line I	(or an a conseque	ence of):		()					
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	c	o (or as a conseque	ence of):								
8760,	certificate be executed iding physician and ise as the burial-transit	lical E			(
687	g £ £			L 0.										
Box	leath certific attending p I for use as 1	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregnar		∃Ectopic p	rennancy	,			Į.	Date of deliv	•
	0 0 0	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of de		Other (s					,	Month	Day Year
<u>о</u>	The law requires that the date has been signed by the page 2 should be detached	Phy	9 ☐ Unknown Part II. Other significant conditions			Iting in the u	nderlying	ause div	en in Part	1	23e. Did to	obacco use co	ntribute to	the cause of death?
Records,	signe d be d	by	Donatote		- Court but Hot Toour	ang in the a	indonying (Jacob g. r	on arr arr	••	10		. /	bably 4 □Unknown
S	v requ been shoul	Completed	A colean								24a. Was	an 24h	Were aut	opsy findings available
Æ	he lay e has	дшо		P-10_							autor perfo	rmed2	prior to co death?	ompletion of cause of
Vita	siclan: The law s certificate has t lirector, page 2 s	Be Cc	25. Was case referred to medical					Setos	26. Plac	e of Deat	1 Yes h (Check only o	2 No	1 □ Yes	2 No
2	nysicl iis cer direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1	Inpatient 2 E	ER/Outpatie	nt 3 D	OA Cth	ier: 4□N	lursing Ho	me 5 Resid	dence 6 □C	ther (Spec	ify)
0 0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending		e of Injury onth, Day Year)	28b. Time o Injury	of	28c. Injur Wor			28d. Describe	how injury occ	urred	
Division or	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not l	00	an of injury. At hou	me form at	M		Yes 2□]No	006 Landing (Change and Alive	mhan an Du	nd Davida Alcumbas
\leq	or Al	Certification:	4 Homicide determined	200. I lat	ce of injury - At hor lding, etc. (Specify)		reel, racioi	y, onice			City or Tox		nber or Hui	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;				he best of my knov									
	n 24 h	Medical	(Check only 2 Medical Exa		basis of examinat anner stated.	ion and/or ir	nvestigatio	n, in my o	opinion, de	eath occu	red at the time,	date and plac	e, and due	to the cause(s)
_	To til withi To til com	ž	29b. Signature and title of certifier	6			29	c. Licens	se number		- ,	29d. Date sign	_ 1	
			1 John 18	sul.	1			200	760	> ナ >	>6	71		00 g
	5+14		30. Name and address of person who	completed ca	use of death (Item	23a) (Type,	Print)	f 1	2 M	AID	3, 12	=184	m . u	40
	Sta		31. Date filed (Month, Day, Year)		Registrar's Signat	ture	-4		/ !		- , , , ,		, , ,	``\`
	Regist		1111 0 8 200		Le It	Ann								

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last)

Physician Clarence Arlo 2008 Cummins July 15 11:35A [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Dec. 11, 19 College View Center Frederick 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral 1**⊠** M 2□ F Months 174-34-7562 65 Pennsylvania Director 1942 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Event har must be notified at once. Funeral Director 1 Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2633 Mill Race Rd. 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1964-67 1 ☐ Yes 2X No 2 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Homer Wray Cummins ည Salena McKim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2633 Mill Race Rd. Priscilla Ann Cummins/wife Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State County Cremation 7/17/2008 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician robable disease or condition resulting in death) /Medical Due to (or as a consequence Examiner kinsons disease Stage Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 □ Yes 2 - No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1. Natural 5 Pending investigation Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MI 21707 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65 Hemen -6 Thomas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2

Year

2. Date of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Karen Naomi Connolly July 2, 2008 0440 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll 1805 Connolly Dr. Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2 🔀 F Months Days Hours Yrs Director 213-52-9603 Dec 17, 1946 Maryland 61 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modicial Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? Funeral 1805 Connolly Dr. 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2☐No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7/s th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Commercial Artist self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Sterling L. Connolly Naomi B. Bond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traunonce. Douglas M. Lawless Husband 1805 Connolly Dr. Westminster, MD 21158 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 7/7/2008 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park Parkville, Maryland 22. Name and Address of Facilities Funeral Home & Chapel, PA 21. Signature of Funeral Service Licensee well 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 10 moutos /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) 68760. Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 ☐ Other (specify) signed by the a d be detached for P.0. 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No should peen The law 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s 24a. Was an autopsy certificate Vital 1 □Yes 1 ☐Yes 2 ☐No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1∐ Yes 2 00 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii Residence 6 ☐ Other (Specify) of this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

JUL 07

South (

7/2/08

LESTHILSTER HD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Amend 26 per phys, DOR, Registrar 7/7/08, LDB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 9:00 PM 28 2008 osa Ann JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Arrington Koad ueenstown Queen Anne's 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12-56-8884 1 M 2 M F Min. Months Days Hours Director JuNez Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notifled at 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Directo orches ambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 02 2/6/3 Funeral Was Decedent Ever in U.S. Armed Forces? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 do 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 1 No ≥ Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ne Operator lectronics or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rooseve ၉ eterson permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is marl any Injury or other traumati 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kat 8 Arrington Rd. Queenstown, MD, 21658 tewart he 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Shore Cremation Cambridge, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY FUNERAL HOME,
510 Washington St. C. 21. Signature of Funeral Service Licensee Lambridge, MD.21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician etasta months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-trar attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has by page 2 s autopsy performed? Yes 2 No this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home SMRsidence 6 MOther (Specific Sidence Mother's Hospital: 10 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred H.fter 1 Natural 5 Pending investigation Injury To the Hospital or Attendia within 24 hours elter death. To the Funeral Director: 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day

Purdy Street, St. 101, Easton, MD

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

Mary Spencer DeShields, M.D., 401 Pure

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ELVA NATALIE CAIN 3:52 AM July 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Nursing Havre de Grace Harford 5. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 217-50-2390 1 □ M 2 🗙 F 93 Director APRIL 30, MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 X Yes 2 No Directo MARYLAND HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. 415 S. MARKET STREET 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or Items ledical Examiner n Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK ģ 3 XWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOLS TEACHER marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KENTON PRESBERRY DORA BOND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra LLOYD CAIN / SON 511 SECOND STREET, ABERDEEN, MARYLAND 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BERKLEY CEMETERY 07/09/08 DARLINGTON, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licenses LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 07 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sonsequence of requires that the death certificate be executed Exami the burial-tran Due to (or as a consequence of): ivision or Vital Records, P.O. Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 WNo Month Dav Year signed by the a 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ trobe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2 No 1□ Yes Be director 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Other: 4\sqrt{Nursing Home 5 \sqrt{Residence 6 \sqrt{Other (Specify)}} 20 No Hospital: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred A fter 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) S, UNION AVE, HAURE DEG . Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0.8 2008

32. Registrar's Signature

			For State Registrar	State of Ma	ryland	-	rtment of H tificate of L			iene eg. No. 2	nna	22225
f	Physicia	an	Decedent's Name (First, Middle, John		Corbe	t t			2. Date of Deat Month June 28	Day	Year	3. Time of Death 11: 26 AM
*	/Medic		4a. Facility Name (If not institution, g	give street and number)	COLDE		4b. City, Town, or	Location of Death	Julie 20		nty of Death	11-20-
•		4	165 Shamrock Dr		//n /no	t histholous)	Salisbu	lry If Under 24 Hrs.	8. Date of Birth		omico	ace (State or Foreign
	Funeral Director		217-14-8988	4 NZM OFF	(In <i>yrs. l</i> as	Yrs.	Months Days	Hours Min.	07/29/1	Year)	Coun	y land
	yland now at		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Ba-f sl	ctor	MD Wico	mico	Sa	lisbu	-					12X Yes 2 □ No
	a or 2	Dire	10e. Street and Number 165 Shamrock Dr	ino			10f. Zip Code 218	20%	1		of What Coun	try?
	ms 23	Funeral Director	11. Marital Status	12 Was Docadont E	ver in U.S.	13. \		ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. F	lace - Americ	
36	be filed within 72 hours after death with the Maryland tial Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? Armed Forces? 1 X es 2 N If Yes, Give Year or Dates:			r Yes, specify Cuba I∐Yes 2 <mark>X</mark> No	Specify:	(Rican, etc.)	Spe	cify: White,	ite
9	2 hour atural		15. Decedent's	Education		16a. Deced	lent's Usual Occup	ation	. I	16b. Kind of	Business/Inc	
The state of the s											ctiona	L
2	led wi lygien her th nt, the	Co	17. Father's Name (First, Middle, La	1	1	Corre	ctional O	Officer 18. Mother's Nam			cution	
Maryland	w = 0 m	To Be	John William Co	,				Margare	,		,	
ary	shou and M is mar	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Number or Ru				Code)
σĵ S	and sealth m 27		Michael Corbett	/Son	John Blo	120	Roseberry sition (Name of	Avenue,			2180	
20.	ages 1 nt of 1- :: If ite		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3		cer	netery, crei	natory or other plac	ce) ; Gar. 7/1			ı, Mar	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic en once.		Donation 5 ☐ Other (Special Service Li		J SP Z			ss of Facility.			.,	y Luna
m —	any per	5	Drus L VUKI	raits MOI	0295	- 1		rset Ave		ess Ar	ne. M	21853
	Physician /Medical Examiner		2 a. Part1. Enter the disease, or c shock, or heart fallure. List o mediate Cause (Final isease or condition resulting in death)	nly on cause on each lin	ne.	Canc		ng, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Death
ä	\$	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or as a	a conseque	ence of):						
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a conseque	ence of):						
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_			IF FEMALE:	23c. If yes, outcome								
.O. Box	The law requires that the death certificate has been signed by the attending progge 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	у		23d.	ery Day Year					
<u>α</u>	s that t ned by e detac	by Ph	Part II. Other significant condition	s contributing to death but	ut not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use c	ontribute to t	he cause of death?
ord	equire en sig ould b	ed b				·			1 □ Y	'es 2□N	o 3 Pro	pably 4 Unknown
Records,	Physician: The law r this certificate has be al director, page 2 sh	Completed							24a. Was autop		prior to co death?	opsy findings available mpletion of cause of 2 No
or Vital		Be C	25. Was case referred to medical examiner?				1.5	26. Place of Dea	_		1 🗆 163	20140
ار د	Physician: r this certifica ral director,	P	1 ☐ Yes 2 No	Hospital:		R/Outpatie		4 Li Nursing H	ome 5 Resid			fy)
ono	ng l fter ner	tion:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigs			Injury	Wor	rk? Yes 2∐No	28d. Describe h	iow injury oc	curred	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be 280 Place of inju			reet, factory, office		28f. Location (S City or Ton	Street and No vn, State)	umber or Rur	al Route Number,
	e Hospit: 24 hours e Funera letely fille	Medical C		Physician: To the best xaminer: On the basis of and manner sta	f examinati							
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Licens			29d. Date si	gned (Month,	Day, Year)
			16 Be Why	Silian			H	57291		61	30/200	8
			30. Name and address of person v	who completed cause of d				OI Talis	bung, ori	0 2180	4	
+	St	ate	31. Date filed (Month, Day, Year)	2000 32. Registr	ar's Signat	re	South.	.~1	/1	•	•	
	Regist	rar	30L 0	1 C000	we.	A A	goests)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day TUNCUS LO Carrens 2005 0340 27 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Conty Columbia General 7. Age (In yrs. last birthday) Marinh If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
June 10, 1911 Puerto Rico 5. Social Security Number 1**∑**M 2□F Months |723**–**18**–**0193 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9420 Ridgeview Lane 21046 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1X Yes 2□ No Specify: Hispanic Specify: 3 ☐ Widowed 4 ☑ Divorced Puerto Rican 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Paint Company Chemical Process Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bonafacio Carreras Maria Otero 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonita Carreras Williams/daughter 8022 Laketowne Court Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Chesapeake Crematory: 07/05/08 Beltsville, MD 21. Signatural f Funeral Service Lice 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prevnou Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? 2 □ No Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 ER/Outpatient 3 DOA

Physician /Medical Examiner the death certificate be executed and bunial-tran P.O. Box 68760. attending physician the

has

certificate

this

Physician

Examiner

Funeral

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore.

Records,

Division or Vital

or Attending Physician:

Hospital

iges 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Menhal Hyglene.

It of Health and Menhal Hyglene.

It filem 27 is marked other than "naturat", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau

/Medical

MD

Director

Funeral

Completed by

Be

Examiner Physician/Medical as jo signed by the a Be Completed 2 within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral Certification:

1 Tes

25. Was case referred to medical examiner? 2 No 27. Manner of Death

5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

1 Inpatient 28a Date of Injury 28b. Time of (Month, Day Year)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

BALTIMORE, MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

HATLA

29b. Signature and title of certifier 29c. License number

RES 0000

29d. Date signed (Month, Day, Year) 3,2008

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 0 8 2008

SINGHI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gus

32. Poistrar's Signature

NORTH

DHMH 17 Rev 1/200

WOLFE ST

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** July Linda Marie Dillinger 05 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Peninsula Regional Medical Center Wicomico Salisbury, MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Director 220-52-8261 May 9, 1947 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Sussex Lewes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34315 Edgewood Drive 19958 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Elementary Education** School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Olin Woodrow Dennis Virginia Marie (Hambley) ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monroe Dillinger / Husband 34315 Edgewood Dr., Lewes, DE 19958 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Eastern Shore 20c. Location - City or Town, State Date Department of Important: If it any Injury or conce. 4 □ Donation 5 □ Other (Specify) ÷ 07/10/2008 Lewes, DE Crematorium 21. Signature of Funeral Service License 22. Name and Address of Facility Parsell Funeral Enterprises, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia **Physician** Agairation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Neuroectodernal Tumor Metestation Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division of Vital Rec&rds, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Cherotherapy-induced neutro genic 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed thrombous topenia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 □ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ၉ this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.O. 030690 30. Name and press of person who completed cause of death (Item 23a) (Type, Print) MARTIN. E. M.D. 145 E. Carroll St. Suit A-1 Solisbury MD 21801 Registrar's Signature 31. Date filed (Marie Dar 9ar)2008 State

Registrar
DHMH 17 Rev 1/2001

08-04989

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Elizabeth Davis State of Maryland / Department of Health and Mental Hygiene 2008 23388 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 28, 2008 0831 hrs Elizabeth Elaine Davis **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Somerset 27187 Fairmount Road Westover If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Country) Months Min. Days Hours 89 02/19/1919 219-03-7640 Director 1 M 2 X F Yrs Maryland Usual Residence of Decedent 10d. Inside City Limits ıny 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene and It filed the 27 is marked other than "natural", or items 23a or 28a-f show and the traumatic event, the Medical Examiner must be notified at once. Somerset Westover Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 27187 Fairmount Road 21871 Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes White Yes 2 No specify: Specify: 3 Widowed If Yes, Give Year Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clothing none Seamstress 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Meredith Nettie Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrin M. Taylor/Grandson 10694 Toddville Road, Chance, MD 21821 Baltimore, I permit. Pages 1 and Department of Healt Important: If item injury or other trav 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 7/1/2008 Salisbury, Maryland Salisbury Crematory Donation 5 Other Specify 22. Name and Address of Facility
Hinman Funeral Home Signature of Funeral Service Licenses M00295 Somerset Anne at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complications Physician Between Onset and failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease mmediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last hysician/Medical UNPENDED AMENDED has been signed by the attending physician should be detached for use as the burial law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Day past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ā Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Dementia Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page ✓ Yes 2 No 2 No the Hospital or Attending Physician: Tec certificate 1 V Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital director. Be Other₄ examiner? Hospital: 1 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient 2 this 1 Yes No မှ After 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 neral Director: / filled in by the f within 24 hours after death. To the Funeral Director: Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. June 29, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month Pay, strar's Signature

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registra

2008

1 - For State Registrar

David

Physician

1. Decedent's Name (First, Middle, Last)

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	Examir	ner	4a. Facility Name	(If not institution,	give street and nu	dical (inder	4b. City		Location Shu	of Death	1D		NICON	
		_	5. Social Security		. Sex	7. Age (In yrs.	last hirthday	If Unde	er 1 Year		7 er/24 Hrs.	8. Date of Bi	irth		Birthplace (State or Foreig
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	and *		10a. State	10b. County	-	10c. Cit	y, Town or L	ocation							10d. Inside City Limits
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	e M	S	MD	Wicomi	СО		Salisb								
	# # p	iz.	10e. Street and N	umber				10f. Zi	ip Code				10g. Citi	izen of What	Country?
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	ms 3	Je.	11. Marital Status		12. Was Dec	edent Ever in U.	S. 13.	Was Dece			Origin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - A	merican Indian,
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21215-0036	rs a	þ		4 🖾 Divorced	If Yes, G Year or D	ive Dates:	İ	1 □Yes	2⊠No	Specia	fy:			Specify:	White
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≥	1 and 2 Health em 27 i		Kathlee	n Eisenha	auer- Pe	rs. Rep.	713	Colle	ege L	ane	Apt.	3 Sali	sbury	7. MD :	21804
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Baltimore, Maryland	permit. Page Department o Important: If any Injury or once.		21. Signature of F	uneral Service Li	censee A	110	2	2. Name a	and Addre	ss of Fac	B B	ounds	Funer	cal Hor	ne
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<u>Ş</u>	Atte r de ecto by th	1€	3 ☐ Suicide	6 Could no determin	28e. Plac	e of Injury - At h	ome, farm, s	treet, facto	ry, office			28f. Location	(Street ar	nd Number o	r Rural Route Number,
á	afte Dire	Certification: To	4 Homicide		build	ding, etc. (Speci	(y)					City or I	own, State	9)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier	1 Certifying	Physician: To th	e hest of my kno	owledge dea	ath occurre	ed at the ti	me date	and place	and due to th	ne cause/s	s) and manne	er as stated
	Hos Pun Fun	Medical	(Check only one)		xaminer: On the										due to the cause(s)
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	1111		30. Name and ad	dress of person w	no completed cau	se of death (Ite	n 23a) (Type			-				1 /	
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DH	MH 17 Rev 1/2	2001					-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Eisenhauer

Certificate of Death

Reg. No. 2

2008

08

2. Date of Death Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 8:10 p.M Richard Elzey July 2008 4 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester 403 Sandy Hill Road Cambridge If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1**∑**M 2□F June 8, 1924 Maryland Director 216-18-8516 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Dorchester Cambridge MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21613 403 Sandy Hill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★ Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify: white þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within lealth and Mental Hygiene.
m 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) pe service station manager 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Wroten Milton Elzey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trauonce. 403 Sandy Hill Road, Cambridge, MD Nancy Richardson daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/9/08 Church Creek, MD Old Trinity Churchyard 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Li Thomas Funeral Home P.A. 21613 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Bladder **Physician** 3 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Exami that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Anemia Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Buencusm 24a. Was an Hortic has autopsy Fibrillation Barial certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes ♠ No ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Hatural Injury 5 ☐ Pending 1 ∏Yes 2 ∏No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.O.

requires that the death certificate be executed Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

death with the

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of dertifier

042816

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

💋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) (Lichard

Burganne

mp 555 Cynwool Or. Easten MD 21601

Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

23391

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evanting 1, ust be notified at any injury or other traumatic event, I'm Medical Evanting 1, ust be notified at any once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Sta Registr

	- Registrar				C	ertifica	te of	Death			Reg.	No.		, c. o	
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Ç.	Citizens	Nursi	ing Center	r			Fred	erick				F	redei	rick	
	5. Social Security Nu		6. Sex	7. Age (In yrs.	last birthda	y) If Unde	er 1 Year	If Under	r 24 Hrs.	8. Date of E	girth		9. Birth	place (State	or Foreign
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2	Cornelis	J. Er	ndlich					M	laria	Van G	ogh				
	19a. Informant's Na	me/Relations	hip (Type. Print)		19b. Ma	iling Addres	ss (Street	and Numb	ber or Run	al Route Nur	nber, Ci	ty or Town,	State, Z	ip Code)	
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	20a. Method of Disp			20b. F	Place of Dis cemetery, cr				1	Date				own, State	
	1 ☐ Burial 2 ☑ 4 ☐ Donation		3 ☐ Removal from	State	auffer				Jul	y 10, 2008	F	rodori	ick	Mary1a	nd
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Be Completed by Physician/Medical Examiner			Q												
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ciar	in the past 12 r	months?		birth 2 Feta		3 ☐ Ectopic 5 ☐ Other (у					onth	-	Year
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ical	7 Accident 3 ☐ Suicide	investi 6 ☐ Could	not be	e of Injury - At h	omo form			ites 2L	1140	OOL Location	. (01	A = = = 1 A £ === 1		-10-4-1	
in in	4 Homicide	determ	nined 20e. Flac	ding, etc. (Speci	ify)	street, lacto	ry, onice		1	City or	Town, S	tate)	per or Hu	ıral Route Nur	nber,
Medical Certification: To	29a. Certifier	1 O Carrieria	ng Physician; To th	a hast of multi-	owledge d	ath occur-	ad at the at	mo deta	and plan	and due to	the sec	20(0) 25 -	oppos = -	atated	
lica	(Check only one)	Medical	Examiner: On the	basis of examin	ation and/or	rinvestigati	on, in my	opinion, de	eath occur	rred at the tin	ne caus ne, date	and place,	and due	to the cause	s)
one) and manner stated. 29b. Signature are title of certifier 29d. Date signed (Month, Day,									n Dav Year						
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			For		State of Ma	aryland				lealth and N	lental Hy	/gien	e				
		_	= State Registrar				Ce	rtificate	of I	Death		Reg. No	.200	0	23302		
Physi	cia		1. Decedent's Name	41	1						2. Date of Do	Da	2 700 2 700	ar	3(Time/of Death C		
/Med		4	Charlo	11 0	Forrest						7	3:30AM					
Exam	ine	r		ſ	ve street and number)		0 1		11	r Location of Death		40	c. County of D	eath			
	Funeral 5. Social Security Namber 6. Sex 1 Director 219-36-3671 1 M 2DF 96 Yrs. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 26, 1911 1 Sept. 26, 1911											1 9	Rirthnle	ace (State or Foreign			
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in 5, what yearly 2.12.15.0000 s. 1 and 2 should be filed within 72 hours after death with the Marylan feelath and Mental Hygiene. Heath and Mental Hygiene. Hean 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		-			er (Cousin					on Rd. Wa							
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permit. Pages 1 and 2 Department of Health a Important: If item 27 is	ouce.	-	21. Signature of Fu	uneral Service Lice	7 1	MO141		22. Name and A		ss of Facility Funeral	Home S	2525	5 Bradl	ury	Ave.		
			29a Part L Enter I	the disease, or con	nplications that caused	d the death.					- / 1		isburg ,	, Mu .	Approximate		
Discount			shock, or hea Immediate Cause	art failure. List only	one cause on each li	ne.			,	9,		unou			Interval Between Onset and Death		
Physicia /Medica			disease or condition resulting in death)	on	a. <u> </u>	tro	chr	د		\sim	$-/\!\!/-$		* 1	_			
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Nursing Facility 2008 Reschant Way Ingersta 2008 Reschant Way Ingersta 2018 29a. Certifier Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause											gerstain, MD						
the the the the the the the		Med	one) 29b. Signature	title of cortifier	and manner st	ated.		29c 1	Licens	se number		204 D	ate signed (/	Aonth	Day Vaarl		
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State

Registrar

MANDEE MEHRA

31. Date filed (Month, Day, Year)

JUL 0 3 2008

32 legistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Welve

Wander

2 degistrar's Signature

DO06 2717

South Greene St. Baltimore MD 21201

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** acinth July 2008 6:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 14919 Comus Road Boyds Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🛛 F June 26, Director 70 1938 Jamaica 059-44-6192 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? .1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or item traumatic event, the Medical Examinar must be not her traumatic event, the Medical Examinar must be not be an event of the Medical Examinar must be not be an event of the Medical Examinar must be an event of the Medical Examinar must be an event of the medical Examinar must be an event of the event 14919 Comus Road 20841 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify **Black** Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert David Fagan Eileen Isabelle Archer ဂ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other th Caroline-Jo Anne Etienne 14919 Comus Road, Boyds, Maryland 20841 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Germantown Baptist Cem. 7/11/2008 Germantown, Maryland 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Signature of Fun, ral Service Licensee Krul 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardionespirates **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner mis Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed eloperous A cute My and the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ρ Month Day Year 5 Other (specify) 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 2 No 1 ☐ Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ∏ Yes 2 XNo this (1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director: After this

filled in by the funeral di 27. Manner of Death 1 Anatural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Medical

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Center

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Baltimore, Maryland

MD

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32. Degistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year)

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9882 8-8-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\mathtt{Jul}^{\mathtt{Month}}_{\mathbf{v}}$ 2008 **Physician** MARTHA GRACE FAVORITE 2:00 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 15202-B Catoctin Mountain Highway Thurmont Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday, **Funeral** 1 □ M 2 🖵 F 5, 97 Sept. 1910 Pennsylvania Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State "natural", or items 23a or 28a-f show edical Examiner must be notifled at 1 □Yes 2 □ No Director Maryland Frederick Thurmont 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe 15202-B Catoctin Mountain Highway 21788 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Baxter Norma Forney ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an Health a 16536 Sabillasville Road, Sabillasville, MD 21780 Peggy Royer / Daughter permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other: once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State Blue Ridge Cemetery 7/9/08 Thurmont, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servi ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 001 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and use as the burial-trar ie to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown Was a.. autopsy performed? 'as 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 this certificate 1☐ Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 | Inpatient Medical Certification: To funeral 27. Manner of Deat 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural Year) (Month, Day 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, or Attending Physician: To the Hospital or Attena within 24 hours after death To the Funeral Director:

State

filled in by

completely

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cau e of death (Item 231) (Type, Print)

🗡 _rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. 2 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day SLIV PM aris Sevall 30 0 Ь /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country)
_____ 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Days Hours Min. JANUARY 29, 1942 375-48-4689 66 GREECE Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modical Examinar must be notified at Director 1 ☐ Yes 2 X No MARYLAND | ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1889 BURLEY ROAD 21409 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No WHITE Specify: 2 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) NAVAL ARCHITECT/ENGINEER DEFENSE DEPARTMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental ALKI GENALIS BETTY PAZOLIDES ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORCAS GRAY/WIFE 1889 BURLEY ROAD, ANNAPOLIS, MARYLAND 21409 permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of CHESAPEARE CREMATION CENTER 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JULY 2,2008 STEVENSVILLE, MARYLAND 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Licenses Will Ethou M00672 23a. Part1. Enter the disease, or complications nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Yult, 010 **Physician** LATE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): 68760. attending physician Physician/Medical Box (IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No ned by the a P.0. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been VEDIAC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform rmed? 2 No 1 ☐ Yes 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) the funeral 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year) 80. Name and addr completed cause of death (Item 23a) (Type, Print) Rd Suite 300 Annipolis MO 21401 Best 900 10200 6. KILLY 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 0 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		4 101	partment of Health and leartificate of Death	Mental Hygiene Reg. No. 2008 2339
Physici /Medic		Decedent's Name (First, Middle, Last) ROBERT HAMILTON HAINES		2. Date of Death 3. Time of Death Month Day Year JULY 13 2008 11:45A M
Examir		4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL	4b. City, Town, or Location of Death FREDERICK	FREDERICK
Funeral Director		5. Social Security Number 217-18-7613 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 1 M 2 F 84	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Mar 12,1924 Mary Land
th with the Maryland 23a or 28a-f show	ctor	Usual Residence of Decedent 10a. State Mary Land Washington 10c. City, Town or Hagers	Location LOWN	10d. Inside City Limits 1 X IYes 2 ☐ No
h with the 23a or 28	Funeral Director	10e. Street and Number 17926 Golfview Drive	10f. Zip Code 21740	10g. Citizen of What Country? U.S.A.
er dea items	ρ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes Give Year or Dates: WW II	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □Yes 2 X No Specify:	Specify: White
d 21215-0036 filed within 72 hours aft Hygiene. ther than "natural", or ant, the Medical Exemi	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of wor one Condruse retired) rtician	king Funeral Industry
land ild be file Aental Hy rked othe	To Be (17. Father's Name (First, Middle, Last) Gherman Benson Haines	18. Mother's Nar Nellie	ne (First, Middle, Maiden Surname) Harriet Thayer
, Maryland 2121 and 2 should be filed within eath and Mental Hygiene, n 27 is marked other than " ner traumatic event, traine			iling Address (Street and Number or Ru 26 Golfview Drive,	ural Route Number, City or Town, State, Zip Code) Hagerstown, MD 21740
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once.		cemetery of	position (Name of ematory or other place) Livet Cemetery Jul	Date 20c. Location - City or Town, State 17, 2008 Frederick, Maryland
Balti permit. Departr Imports any inju		21. Signifure of Funeral Service Licrosco MO0706	22. Name and Address of Facility Keeney & Basfor 106 E Church Stree	d P.A. Funeral Home t, Frederick, Maryland 21701
Physician /Medical Examiner		resulting in death) Due to (or as a consequence of):		Caranoma
68760, Cf	edical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):		Cenkemia
Box (auth certi attending for use a	Physician/Mec		B	23d. Date of delivery Month Day Year
rds, P.O. quires that the de no signed by the auld be detached to	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
II Rec The law ate has b	Completed			24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
on of Vita ding Physician: n. After this certifica funeral director, I	lo Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No	Othor	ath (Check only one) Iome 5 ☐ Residence 6 ☐ Other (Specify)
r g age	ation:	27. Manner of Death 1 ★ Natural 5 Pending 2 Accident Spending investigation 28a. Date of Injury (Month, Day, Year) 28b. Time (Month, Day, Year)	of 28c. Injury at	28d. Describe how injury occurred
n b	Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
e Hospital (24 hours a Puneral Dietely filled i	dical	29a. Certifier (Check only one) (Check one) (Check only one) (Check only one) (Check one)		
To the within 2 To the comple	Me	29b. Signature and title of certifier My / Lee Nam	29c. License number D63516	29d. Date signed (Month, Day, Year) 7/13/2008
13		30. Name and address of person who completed cause of death (Item 23a) (Type Myung Hee Nam, M.D., 400 West Sever	enth Street, Freder	
Sta Registr		31. Date filed (Month, Day, Year)	and a	.1

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 23398 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2:00 P.M. **Physician** John Earl Hoffman, Jr. 2008 VINT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Ye Sept. 2, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Year) 1√2 M 2□ F Months Days Hours Min 214-16-2503 89 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Hagers town Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 U.S.A. 12 S. Walnut St. Apt# 413 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 12 Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Earl Hoffman, Sr. Bessie Charlotte Green ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 749-1 N. Boyd St. Cascade, Maryland 21719 Kathy Louise Pack (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 16, Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO14/4 12525 Bradbury Ave. Smithsburg, Maryland 21783 AVIS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se MSI 0 disease or condition resulting in death) Due to (or as a consequence of): nivator Sequentially list conditions, ner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami oromaru Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 2 Completed

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician: ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t

Funeral

Director

show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified a once.

Physician

/Medical

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Part II. Other significant condition	ons co	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
					1 □ Yes 2 □	No 3□ Probably 4★Unknown
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medica examiner?	J			26. Place of De	ath (Check only one)	
1 Yes 2 No		Hospital: 1 ☐ npatient 2 ☐	ER/Outpatient 3 🗆 I	Home 5 ☐ Residence 6	☐ Other (Specify)	
27. Manner of Death 1 ☑ Matural 5 ☐ Pendin 2 ☐ Accident investi		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 Suicide 6 Could 4 Homicide determ		28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	i Number or Rural Route Number,
29a. Certifier 1 Certifyii (Check only one)	ng Phy Exam	/sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and plac on, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)

State Registrar Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23 arte of Maryang/ Department of the absended to the property of 1 - For AI State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12,2008 **Physician** JULY 9:15P LYNN EDGAR JONES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES 5650 PORT TOBACCO ROAD INDIAN HEAD 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign N Quentry) **Funeral** Months Davs Hours 072-16-1850 86 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show MD. CHARLES 1 □ Yes 🔏 No INDIAN HEAD must be notifled Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code ь U.S.A. 5650 PORT TOBACCO ROAD 20640 23a death y Funeral r than "natural", or items the M dIcal Examiner mu 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Forces:

1 Kes 2 No NAVY
If Yes, Give
Year or Dates 20yr.ret within 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: 2 Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within und Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U. S. NAVY YEOMAN FIRST CLASS 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi and Mental H BERTHA RICHEL EDGAR N. JONES and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traum DOROTHY JONES/SPOUSE 5650 PORT TOBACCO RD. INDIAN HEAD, MD20640 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition $\mathsf{JULY}^{\mathsf{Date}}$ 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 15,2008 ALEXANDRIA, VA METROPOLITAN CR. 21. Signature of Funeral Service License 22. Name and Address of Facility RAYMOND FUNL, SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24 KAN /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine burial-tran Due to (or as a consequence of): physician at the burial pe Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f o 9□Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş Complications of Right Pelvis and Left Hip Fracture 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

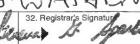
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1 Yes 2 No Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending Parter death. After Injury 5 Pending Subject fell 2 Accident 1 ☐ Yes X No investigation Unknown **Unknown**^M the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Subject fell Unknown Unknown To the Hospital within 24 hours at To the Funeral D Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) 1 2008

29b. Signarye and title of certifier



and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	Marylan		artment <i>rtificate</i>			d Me		giene Reg. No. 2	200	8	23400
	Physici /Medic		1. Decedent's Name (First, Middle Joyce F. John	,,							Date of Dea Month	Day	2	rear	3. Time of Death
	Examir		4a. Facility Name (If not institution Anne Arunde1 5. Social Security Number	Medical			Ar	napo	ocation of D 115 f Under 24 h		Date of Birt	4c. County of Death Anne Arunde			nde1 ace (State or Foreign
18	Funeral Director		214-48-1347 Usual Residence of Decedent 10a. State 10b. County	1 □ M 2 □ X F	10c. City	62 Yrs.	Months			lin.	(Month, Day	1945	5	Tex	a.S.
	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	faryland Anne 10e. Street and Number 1818 I Copela 11. Marital Status		dent Ever in U.	Anna po	10f. Zip	21401 ent of Hisp		(Specif	y Yes or No		JSA I. Race -	at Count	n Indian,
9000-	2 hours after atural", or Ite cal Exa <u>mine</u>	by	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	ed 1 Tes If Yes, Giv Year or Da	2 X No e	16a. Dece	1 □ Yes 2	No S	Specify:			16b. Kind	Specify:	Bla	ck
Maryland 21215-0036	filed within 7; Hygiene. Ither than "n	e Completed	(Specify only highes Elementary/Secondary (0-12) 10th 17. Father's Name (First, Middle,	College (1	-4or 5+)	(Give life. L	kind of word DO NOT usi	e retired)	ing most of		First, Middle,				aryland
arylan	2 should be and Mental is marked or raumatic eve	To Be	Theodore Watt	s Sr		19b. Mailir	ng Address		C1ai	rre	sa Co	lema	n		Code)
Baltimore, Ma	permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic enonce.		Angela McKinn 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)	3 □ Removal from \$	20br P	1818 moria	sition (Nam	e of her place)	1	t. Dat 3-0	9	20c. Loca	ation - C	ity or Tov	21401 vn, State 11e, Md.
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service	Licensee	3	8	21 We	est S	St. A	nna	Mortu polis	, Mo			1
8760,	Physician /Medical Examiner the burial-transit	dical Examiner	23a. Part1. Enter/the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Compared to the control of the co	or as a consequence or as	uence of):			Dist						Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certifit te has been signed by the attending prage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live b	come pf pregna irth 2 □ Feta ant at time of d own	Ideath 3□	Ectopic pre Other (spe					23	d. Date Mont	of deliver	y Day Year
ords, P	w requires that been signed b should be deta		Part II. Other significant condition CEREBROWA	scupe	_	•	nderlying ca	use given	in Part I.		23e. Did t	- 4	,		e cause of death? ably 4 □Unknown
al Reco		Completed by	DEMENTI	1						_	1□ Yes	osy rmed? 2011 No	pri de	or to con ath?	sy findings available inpletion of cause of
Division or Vital Records,	ng Phys fter this ineral dii	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig	28a. Date of (Mont	· 7,	ER/Outpatien 28b. Time of Injury		A Other: Bc. Injury a Work?	4 ☐ Nursir	ıg Home	5 Resid. Describe I	dence 6		. , ,)
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral in the fu	l Certification:	3 Suicide 6 Could n 4 Homicide determi	ned Zoe. Place	of injury - At hong, etc. (Specify	y) 			date and		City or Tov	vn, State)			Route Number,
	To the Hos within 24 ho To the Fun completely	Medical	(Check only 2 Medical one)	Examiner: On the ba and mann	asis of examina ner stated.	tion and/or in	vestigation,	in my opir	nion, death	occurred	at the time,	date and p	olace, ar	nd due to	the cause(s)
)	Deal	\mathcal{O}	30. Name and address of person	who completed caus	e of death (Item	1 23a) (Type,	Print))57	531			Jur	VE	28	,2008
**	Sta Registr	te ar	30. Name and address of person Mchat Ness 31. Date filed (Month, Day, Yaka)	2008 A	gistrar's Signa	ns Hu ture	y Su	VE.	204	n	illers	ville	, /	n)	21108

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** John Lawrence Jones, Jr. Ju₁y 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Days Hours 1⊠ M 2□ F Months 219-66-4224 51 March 6, 1957 Director Maryland Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Inc. Modical Exertiner must be notified at 1 ☐ Yes 2 X No Director Maryland Howard Mt. Airy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1120 Shaffersville Road 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: <u>6</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other than any injury or other traumatic event. In 12 Concrete Finisher Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John L. Jones, Sr. ပ Annabelle V. Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony E. Jones / Brother 4613 Old Court Road Pikesville, Maryland 21208 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date July 10, 2008 Mt. Airy, Maryland 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Simpson Meth. Cemetery 21. Signature of 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician THROMBOTIC THROMBOCHTOTERIC 9 120105 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been signated by page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 ☐ No NA 1 ☐ Yes 2 **N**0 After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification; To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: / 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DR. Liluje Henre-Tuma Gme D0058542 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore,

Box 68760

P.0.

Division of Vital Records,

Registrar

31. Date filed (Month, Day, Year) 2008 0 7



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY Day 2008 Ye al **Physician** ALBERT THOMAS JENNINGS, JR. 6 11:48A M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** MONTGOMERY BETHESDA SUBURBAN HOSPITAL 8. Date of Birth (Month, Day, Year)

JULY 22 1917 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F ΝΥ 90 124-12-0558 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be retified at 1 ☐ Yes 2 No Director MONTGOMERY **BETHESDA** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20816 5100 WISSIOMING ROAD USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No1 942 — If Yes, Give 1 946 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry STATE DEPARTMENT College (1-4or 5+) Elementary/Secondary (0-12) U.S. GOVERNMENT ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HELEN GOVE ALBERT THOMAS JENNINGS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5100 WISSIOMING RD., BETHESDA, MD 20816 LAURA JENNINGS / SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place)
BOYDS PRESBYTERIAN 7/10/08
CHURCH CEMETERY 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BOYDS, MARYLAND 4 □ Donation 5 □ Other (Specify)
Signatur 1 □ ner I Service Licensee 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PMEUMUNTA Immediate Cause (Final **Physician** 21WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of): VAMOVS CITL CARCINOMA METASTATIC 6 MONTH Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SKIN CANTUR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Vital a No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 Ño Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 053367

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2008

leted cause of death (Item 23a) (Type, Print) SMYAMSVNDAN RAJAN
ANENUE, SU NE: 117, SLUMSPRING, MD: 20902

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Francis Edward Krietz 0 04 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 9808 Keysville Road Emmitsburg 8. Date of Birth (Month, Day, May 25, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F Maryland 80 219-20-1569 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 XNo Emmitsburg Frederick Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 21727 **USA** 9808 Keysville Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event, the i once. Cook University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lottie Shorb Cecil Krietz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17339 N. Seton Avenue, Emmitsburg, MD 21727 19a. Informant's Name/Relationship (Type. Print) Barbara J. Beavers, daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) New St. Joseph's Cem 7/8/2008 Emmitsburg, MD 22. Name and Address of Facility Myers-Durb raw Funeral Rome Funeral Service Licensee 21. Signatur 210 W. Main Street, Emmitsburg, MD 21727 an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NON-8MALL CELL LUNG CANCER MONTHS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy 1□ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of 1 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death. filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 031761 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O'CONNOR SEVENTH ST. Date filed (Month, Day, Year) 32. Begistrar's Signature State **JUL 0 7** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Georgia Mae Kennard July 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital E1kton Cecil If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗷 F 236-20-6170 Director 86 June 26,1922 Shady Springs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location a or 28a-f show t be notified at show 1 ☐ Yes 2X No Director MD Ceci1 E1kton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a 11 Hickory Lane 21921 : If item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must i USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No
If Yes, Give
Year or Dates: 1943 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: white Specify: ۵ 3XXVidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Secretary State of Delaware 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Clay Cosby Massie ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any Injury or other tra Joseph Kennard (son) 860 Bouchelle Road Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silverbrook July 8,2008 Wilmington, DE 21. Signature of Funeral Service Licensee Crement of Address of Facility MOOF McCrery Funeral Homes, Inc. 23a. Part LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** middle cerebral disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a Division or Vital Records, P.O. s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by to Or (gotson 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Hypertension 1□ Yes 2 No Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 1 🔲 Yes 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide Hospital 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 450mg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57 / VA Hospital 106 Bow St Elkton MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

JUL 0 8 2008

amend line 15 per fd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 07/03/08 dlwState of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3 Bay 2008 Francis L. King June 7:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth A Month, 9ay, Year) 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Maryland 1**X** M 2□ F Months Days Hours Min. 212-72-8429 66 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 23a or 28a-f show Maryland Anne Arundel Annapolis Directo 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3016 Arundel on the Bay Rd. 21403 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. r than "natural", or items the Medical Exertment Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: hours after Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: à Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier ' is marked other th None nza N/A None N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Lee King Corinne Disney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is r any Injury or other traur Nicholas Weed (Brother) 2198 Patapsco Rd. Finksburg, Md. 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Nichols Bethel Cem 7-3-08 Odenton, Md. 4 ☐ Donation 5 ☐ Other (Specify) Mame Cass of Facilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 B. Seese MOH83 arry 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Se. **Physician** disease or condition resulting in death) /Medical Due to (of s a consequence of): Examiner Dueumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events iner Di to (or as a consequence of) The law requires that the death certificate be executed Exam burial-tra resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the as IF FEMALE: use 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery jo 3 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ed by t been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate I∐Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ER/Outpatient 3 □ DOA Certification: To 1 Inpatient funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D2708 6-30-2008 MD nd address of person who completed cause of death (Item 23a) (Type, Print) Annopelis MD Peterson up 31. Date filed (Month, Day, gistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 19,55 f M JULY 15 John Wesley Logan, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner UNION HOSPITAL OF CECIL COUNT ELKTON CECIL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** Days 1 M 2 □ F May 20, 1951 Maryland Director <u>219-56-4853</u> Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show r 28a-f show notified at 1 ☑ Yes 2 ☐ No Director Ceci1 E1kton Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 21921 United States 283 A Hollingsworth Manor, Road 13 Funeral death 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🎇 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Completed by Specify: 3 Widowed 4 Divorced White th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grocery Clerk/Grocer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Dorothy Hope Montgomery John Wesley Logan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 21921 283 A Hollingsworth Manor, Road 13, Elkton, MD Vicki L. Logan/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) R. A. Ferris & Co., Inc. 2008 West Chester, PA 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BLEED GI Physician /Medical Due to (or as a consequence of): Examiner CIRR HOSIS Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner METABOLIC ACIDOSIS The law requires that the death certificate be execute use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | John Nown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Yes 2 No death? 1 ☐ Yes 2□ No To the Hospital or Attending Physiclan; 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27, Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death.

neral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 63486 JULY, 15, 2008 diress of person who completed cause of death (Item 23a) (Type, Print) 106 BOW STREET ELKTON Registrar's Signature 31. Date filed (I State Registrar

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Physicia /Medic				Shirle		na La	ascko				July	14	20	Year 008	0928	A M
Examin	er	4a. Facility Name (I			number)			4b. City, Town, o		of Death		40	Cec:			
Funeral		5. Social Security N		6. Sex 1 ☐ M 2 💢 I	_	e (In yrs. I	ast birthday			r 24 Hrs.	8. Date of B	irth ay, Year			lace (State or	r Foreign
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er deat tems	Funeral	11. Marital Status		12. Was D	Forces?		S. 13	. Was Decedent of H If Yes, specify Cuba		rigin? (Spe an, Puerto	ecify Yes or N Rican, etc.)		14. Race	- America	an Indian,	
urs afte al', or i xamir	by	1 ☐ Never Marr 3 ☐ Widowed		If Yes,	es 2 🔀 l Give r Dates:	No		1 ☐ Yes 2 🏋 No	Specify	<i>/</i> :			Specify:		ite	
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed	(Spec	15. Deceden	t's Education st grade complete	ed)		16a. Dece	edent's Usual Occup e kind of work done DO NOT use retired	ation during mo	st of work	ing	16b. h	Kind of Bu			
within iene. than '	dmc	Elementary/Seco			e (1-4or 5	5+)		DO NOT use retired 11 ections					Bank	ina		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na		_{nip (<i>Type. Print)</i> ko/Husba}	ınd			ing Address <i>(Street</i> Buttonbush				-	219		Code)	
es 1 al of Hea fitem rothe	1	20a. Method of Disp	position	3 □Removal fro		20b. Pl	lace of Disc	osition (Name of ematory or other place	1	July	Date	T	ocation -		wn, State	
t. Pages tment of tant: If it		4 ☐ Donation	5 Other (S	pecify)	JIII State	Har		morial Gard		2008			Aber	deen,	MD	
permit Depar Impor any in		21. Signature of Fu	ineral Service	Licensee	4 =	`	I	22. Name and Addre	e for	Fune	rals,	P.A.	M	D 01	001	
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Physician		Immediate Cause (disease or conditio resulting in death)	(Final	_a. A 40	yrc	610	ig &								Onset and D	eath
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The law ate has by page 2 sh	ошо							-			auto	opsy formed?	p	rior to cor eath?	npletion of ca 2□ No	use of
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or Atta	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ	ined 286. Pl	ace of inju ilding, etc	ury - At hor c. <i>(Specify</i>	me, farm, s	treet, factory, office			28f. Location City or To			r or Rura	l Route Numb	ber,
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier	1 Certifyin	ig Physician: To	the best	of my knov	wledge, dea	th occurred at the tir	me, date a	and place,	and due to the	e cause(s) and ma	nner as st	ated.	
the Ho hin 24 the Fu	Medical	(Check only one)		examiner: On the	e basis of	t examinat ated.	ion and/or i	nvestigation, in my o	opinion, de	eath occur	red at the time	e, date ar	nd place, a	and due to	the cause(s)	
To COI	-	29b. Signature and	. / /	Tus				29c. Licens	ie number	190		29d. D	ate signed	(Month,)	Zan S	
1		30. Name and addr	/	who completed c	ause of d	eath (Item	23a) (Type	, Print)				<i>ر</i>	0.1	1/		
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MH 17 Rev 1/20	001															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 2, 2008 **Physician** 6:45 PM Luciano /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick College View Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number **Funeral** Months Days Hours 1 □ M 2X F Oct. 4,1923 New Jersey 84 Director 147-16-1044 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanting must be expensed any expense. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No Director Florida Volusia Deltona 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 32725 United States 1851 Elkcam Blvd. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Yes. Give Specify Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna L Jervis ဥ Leon N. Pennington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1810 Rocky Glen Drive, Frederick, Maryland 21702 Beth Davis-Reinhold/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Stauffer Crematory Inc.7/6/2008 Frederick, Maryland 4 Donation 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 21. Signature of Janera Ser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only policause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** omyo /Medical resulting in death) Due to (or as a consequend of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ysician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) physician the burial Box 68760 Physician/Medical attending p IF FEMALE yes, outcome of pregnancy

Live birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 5 Other (specify) □Yes 2√No Ö been signed by the should be detached 9 Unknown 9 ☐ Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 2 🗆 No 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ 🗡 Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in 24 hours a Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one)

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State Registra

29b. Signat

and title of certifier

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31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amended #19a 20b per FH FCHD Certificate of Death KS 7/15/08 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Edith Feulner Lutz July 2008 1:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🖾 F **Director** 85 352-18-9015 July 26,1922 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Madical Examinat be notified at agnee. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits I Hygiene. other than "natural", or items 23a or 28a-f show vent, it a Medical Experiment must be notified at Director 1 ☐ Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5686 Crabapple Drive United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 ™ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Newsday/Advertising 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ John Feulner Bertha Joos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drew Lutz/ Father Son 8304 Jordan Valley Way, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pinelawn National Cemetery7/9/08 4 ☐ Donation 5 ☐ Other (Specify) | Pinelawn, New York 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE disease or condition resulting in death) WERK /Medical Due to (or as a consequence of): Examiner ACUTE myo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the conditions of the cause Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Day Year 5 ☐ Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has I page 2 s portensia his certificate I 1 □Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation I Director: Af 2 🗋 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral [29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 Physician MANCY 0710 July 3, LOSEMARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Emmitsburg 17306 Riffle Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 18, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F 61 205-36-9783 1946 Virginia Yrs Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at Emmitsburg Frederick 1 ☐ Yes 2 No Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21727 USA 17306 Riffle Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or items the Medical Examiner mu 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 lith and Mental Hygiene. 27 is marked other than r traumatic event, the Me College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Leftler Roland Davis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17306 Riffle Road, Emmitsburg, MD 21727 19a. Informant's Name/Relationship (Type. Print) Lacy A. May, daughter item 27 other t 20b. Place of Disposition (Name of Seamplany, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 5 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ± ö Department of Important: If any injury or once. Carroll Crematory 7/5/2008 Winfield, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W. Main Street, Emmitsburg, MD 21727 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HEUTE MYCCARDIAL IN HAROTION disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Due to (dr as a consequence of) DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-tran-Due to (or as a consequence of): Box 68760, Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tyes 2 No 3 ☐ Probably 4 █ onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has lirector, page 2 s autopsy perform 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 A Residence 6 Other (Specify) ᇋ 1 Yes 2000 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? funeral 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation n 24 hours after death. The Funeral Director: Aft 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

			For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death		giene _{Reg. No.} 2008 23412
	Physicia /Medic		1. Decedent's Name (First, Middle, Last, Thelma Gertrude	Newland		2. Date of Dea Month July 6	th Day Year 3. Time of Death 10: 10A M
	Examin		4a. Facility Name (If not institution, give Casey House		4b. City, Town, or Location of Dea Rockville If Under 1 Year If Under 24 Hrs		4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 6. Sec. 384–18–0068	7. Age (In yrs. last birthday) N 2 X F 85 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	June 30	9. Birthplace (State or Foreign Country) Michigan
	ie Maryland 8a-f show tifficu	ctor	10a. State 10b. County MD Montgomer	y Germantown			10d. Inside City Limits 1 ☐ Yes 2 No
	ath with th	Funeral Director	10e. Street and Number 21000 Father Hurle		10f. Zip Code 20874	t	10g. Citizen of What Country?
0500-61	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. A file M. 21 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the filed feet of increases to indiffe a state of the filed at the filed and the filed at the filed	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	1 □Yes 2 KTNo	Was Decedent of Hispanic Origin? (all f Yes, specify Cuban, Mexican, Puei 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
0-C Z	vithin 72 ho	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	Į.	16b. Kind of Business/Industry
and z	d be filed w ental Hygie ked other t c event, III	Be	12 17. Father's Name (First, Middle, Last) Forest Bolthouse	Salesp	18. Mother's Na	me (First, Middle, i e Peterso	
-		10	19a. Informant's Name/Relationship (Tv	pe. Print) ibson/daughter 2375	ng Address (Street and Number or F	ural Route Numbe	r. City or Town. State. Zip Code)
paltimore	permit. Pages 1 and Department of Healt Important: If item 21 any Injury or other it once.		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		osition (Name of matory or other place) te Crematory 07/	Date 08/08 E	20c. Location - City or Town, State 3e1tsville, MD
Da	permit Depart Import any Inj		21. Signature of Funeral Service Licens			te, P.A.	Clarksville, MD 21029
	Physician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final	a. Breast Cancer Due to (or as a consequence of):	ter the mode of dying, oddri as cardie	o or respiratory and	rest, Approximate Interval Between Onset and Death
	311	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury	Due to (or as a consequence of):			
,0070	ate be exec hysician an the burial-tr	dical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):			
O. DOX O	To the propriat or Attending Prysician; The law requires that the death certilicate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
colds, r.	quires that en signed b uld be deta	by P	Part II. Other significant conditions con	ntributing to death but not resulting in the u	nderlying cause given in Part I.		bacco use contribute to the cause of death? es 2 ☐ No 3 ☐ Probably 4X Unknown
מו חפכט	n; The law re ficate has bee r, page 2 sho	Completed				24a. Was a autops perfor 1 □ Yes	sy prior to completion of cause of
= :	s certi irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	0.0	ath (Check only or	ence 6 Xother (Specify) hospice
5 i	ath. ath. ir: After thi	Certification: To	27. Manner of Death 1 X Natural 2 Accident 5 Pending investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury			ow injury occurred
	Ital or Atta	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Tow	
	the Hosp nin 24 hou the Funer npletely fil'	edical	(Check only one) 2 Médical Exami	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occ	urred at the time, o	date and place, and due to the cause(s)
	North Con	2	29b. Signature and title of certifier	hho os	29c. License number D64615		July 6, 2008
2	02			empleted cause of death (Item 23a) (Type, Rki, M.D. 1355 Picca		1e, MD 20	0850

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31. Date filed (Month, Day, Year)

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32. Egistrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 11:30p M Joshua Paul Noble June 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 112 East First Street Washington Hagerstown 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 23, 19 Birthplace (State or Foreign Country) **Funeral** Days 1 ₩ M 2 🗆 F Director 163-58-1076 35 Jan. 1973 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 A No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 112 East First Street 21740 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 閏 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No ۵ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, Item. Elementary/Secondary (0-12) College (1-4or 5+) 12 Fork Lift Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Donald C. Noble Linda Bond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Bond / Mother 305 Cone Branch Drive, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc 7/4/2008 | Frederick, Maryland 21. Signatur Funeral St 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes Pike, P. A. Frederick, Maryland 21702 Opossumtown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Jun-Lot /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of) signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 22 No this certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury
N

28c. Injury
N

28e. Plate of Injury - At home, farm, street, factory, office building, etc. (Specify) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☑ No s after death Self Intlided the f 2 Accident JUNSLOT-3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t determined 4 Homicide Kos, dena filled (41810vn

the death certificate be executed P.O. Box 68760, The law requires that Division of Vital Records, or Attending Physician: To the Hospital within 24 hours a To the Funeral C the Hospital

with the Maryland

death

filed within 72 hours after

21215-0036

altimore, Maryland

death.

State Registrar

Medical

29a. Certifier

29b. Signature a

d addres

31. Date filed (Month, Day, Year) 0 8 2008 JUL

of certifier

and manner stated

of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manher as stated.

💯 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar Ce	ertificate of Death	Reg. N	2008 23414
	Physici	an	Decedent's Name (First, Middle, Last) CLIFFORD ERNEST NEAL			ay Year 2008 1:12 P M
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		2008 1:12 P M
	LAUIIII		SHADY GROVE ADVENTIST HOSPITAL		MONTGOMERY	
	Funeral Director		5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday 516-03-1079 12 M 2□ F 92 92 Yrs.	// If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. J (Date of Birth (Month, Day, Year UNE 14	9. Birthplace (State or Foreign Country) MT
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	Maryis -f sho	ţō	MD MONTGOMERY DICKER			1 □ Yes 2 No
	h the	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	ath wii	ral	21511 PEACH TREE ROAD	20842		USA
-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hydiene. Important: If tiem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Even in which our burntified a once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 M No II Yes, Give/ Year or Dates:	. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 🌠 No Specify:	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
2	72 ho natur	eted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working	16b.	Kind of Business/Industry
7	within sne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) CORT	PORATE ACCOUNT	A	DVERTISING
ט ס	filled v Hygie other i		12 EXEC	18. Mother's Name (Fi	irst, Middle, Maide	n Surname)
<u>a</u>	Jid be Jental rked c	To Be	CLYDE ERNEST NEAL	ETHEL (GODDARD	
Mary	nd 2 shou alth and N 27 is ma ir trauma		1 1 21	ling Address (Street and Number or Rural Ro		
altimore,	Pages 1 a lient of He nt: If item ry or othe		20a. Method of Disposition 1 Ma Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	position (Name of ematory or other place) ARM CEMETERY 7/12/		Location - City or Town, State CKERSON, MD
Dall	permit. Departir Importa any inju			22. Name and Address of Facility HILTON FUNERAL HO	P.O	. BOX 86 NESVILLE, MD
	e.		23a. Part 1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
P	hysician /Medical	8 1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	heart direare		Onset and Death Y COLY
E	Examiner					
-	Sit 98	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			21
•	xecur and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C			
	e be e /sician e buria	calE	d			
0	nincar ng phy as the	Medical				
, DO.	to the bropping or Attending Priystcant: The law requires that beant certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
	signed by	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
5	should	letec			24a. Was an	24b. Were autopsy findings available
ב ב	ine ian ite has age 2	Completed			autopsy performed?	prior to completion of cause of death?
2	ertifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (C	1 □ Yes 2 □ N Check only one)	0 1 □ Yes 2 □ No
>	this ce	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	TEST TRAITING TRAITING		6 ☐ Other (Specify)
	After funera	tion:	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day, Year) Injury 2 Accident investigation	of 28c. Injury at Work? M 1 □ Yes 2 □ No	f. Describe how inju	ury occurred
	after deat Director: d in by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
1	e nospire 124 hours e Funera eletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dear only one) 1 Medical Examiner: On the basis of examination and/or and manner stated.			
ļ	withir comp	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
,	5		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) Are Caithul	u mo	20879
ľ	Sta Registr		31. Date filed (Modal Pay, Jean 2008 33 Registrar's Signature	polis	01	/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 5, **Physician** James Tunney Nash, Sr. 2008 5:07 p ^M /Medical 4a. Facility Name (If not institution, give street and number)
Carroll Hospice Dove House 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sep 24, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Min. Hours 1**X**M 2□ F Days Maryland 220-20-2197 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural" --- any injury or other traumatic evera-10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Carroll Westminster 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 2159 Mayberry Road 10f. Zip Code 10g. Citizen of What Country? 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aluminum Extruder Aluminum Corp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward S. Nash, Sr. Nora V. Jefferson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4603 College Ave, Baltimore, MD 21229 Darlene M. Rhoads, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph's Cem. 7/8/2008 Taneytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E. Baltimore St, Taneytown, MD 21787 Jar Approximate Interval Between Onset and Death 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in a PNOMA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events and the burial-trai resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy be detached for in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform certificate 2∐ No Viital Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To Division or nours after death.

neral Director; After this

filled in by the funeral di After this 28a. Date of Injury (Month, Day Year) 27. Manno eath 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

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Direct LUBSTHIUSE , MD 21157

person who completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signature

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2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 U U 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death ∀era Nell Palmer July 2008 <u>12:</u>14P^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 3 Une 4, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 □ M 2 🔀 F OKTahoma 563-38-2568 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2€No Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. 20602 S. A. 3455 F Zinnia Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Pivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Resident Manager Apartment Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Mac Allen Sr. Sarah Ellen Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3455 F Zinnia Court Waldorf, MD 20602 Linda S. Estes/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peter's Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jul.17,08 Waldorf, MD 22. Name and Address of Facility Raymond Funl. Service, P.A. 21. Signature of Funeral Service Licenses **M**00641 5635 Washington Ave., La Plata, MD 29a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Directo for es a nonsequence oty-It any teading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

show

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

within 72 I

12 should be filed whand Mental Hygiel

permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau

certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760 attending physician the as asn jo the certificate

Hospital or Attending

death.

within 24 hours after death

To the Funeral Director;
completely filled in by the

Examiner Physician/Medical þ Completed Be Medical Certification:

1 ☐ Yes 2 ☐No 9 ☐ Unknown	4∐Pregnant at time of death 9⊡Unknown	5 ☐ Other (specify)	
rt II. Other significant condition	ns contributing to death but not resulting in	the underlying cause given	
	-	•	

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

29a. Certifler

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** POCHIBER July 1, 2008 8:00 p м /Medical 4c. County of Death
Carroll 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Westminster Lookabout Manor 8. Date of Birth (Month, Day, Year) Mar 9, 1918 5. Social Security Number 7. Age (In yrs, last birthday, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 □ M 2 🗙 F Pennsylvania 90 208-40-0355 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shov must be notified at Westminster 1 ☐ Yes 2 No Carroll Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 1510 Stone Road USA Funeral 7 is marked other than "natural", or Items traumatic event, the Medical Examiner man 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 ∐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event the sone." Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julia Lecko Vincent Dubovi 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20824 81st Street, Bristol, WI 53104 19a. Informant's Name/Relationship (Type, Print) Mary A. Schumann, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 🕱 Removal from State 7/8/2008 Gilpin, PA St. Catherine Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIO PULMONARY Physician /Medical Due to (or as a consequence of): Examiner 1PERTEN SION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transi Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ MELLITUS cate has been signated page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy 2 10 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) DOMICHUM Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 6 Wother (Specify, funeral (27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

be executed P.O. Box 68760. Division or Vital Records,

attending physician

show

filed within 72 hours after

3altimore, Maryland 21215-0036

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral WJZ

this

After

State Registrar

31. Date filed (Month, Day, Year)

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29b. Signature and title o

30 Name and address of person who completed cause o death (Hem 23a) (Type, Print)

2008

125 Airport #34 32. Registrar's Signature

Westminster MD 21157

29c. License number

29d. Date signed (Month, Day, Year)

ORIGINAL

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gilbert Vincent Riggs, Jr. JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER PLATA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) M 2□ F Months Days Hours 577-78-2828 Yrs. Director 27, 1956 Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location ms 23a or 28a-f sho Directo Maryland Charles White Plains 10e. Street and Number 10g. Citizen of What Country? 8225 Sir Michael Place U.S.A. Funeral 20695 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, I'm Medical Evanting, once. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-003 <u>ک</u> 1 ☐ Yes 2 📉 No 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Project Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilbert V. Riggs, Sr. Louise White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim C. Riggs 8225 Sir Michael Place, White Plains, Md. 20695 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Trinity Memorial Gardens 2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Waldorf, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ROS NCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) P.O. I signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by FAILURE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown TENSION cate has I page 2 s 24a. Was an autopsy performe this certificate 1 ☐Yes 2 XNo 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After thi 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending Certification 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

6 ☐ Could not be

JUL 07

2008

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

29b. Signature and title of pertifier

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIDYASAGAR AMMANGANDUA, M.D. 10583 THEODORE GREEN BLVD WHITE PLAINS IND 20195 31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D-26064

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2008

23418

8:44A

Birthplace (State or Foreign
Country)

Washington D.C

10d. Inside City Limits

Approximate Interval Between

Onset and Death

1 ☐ Yes 2 No

2008

CHARLES

Specify: Black

Month

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Registrar

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

			State of Maryland / Department	artment of Health and N rtificate of Death	Mental Hyg	iene 2008	23419
			1. Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
	Physicia /Medic		James William Reichard		July 6,	Day Year 2008	7:50 P ^M
000.	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
, pr 4			11406 Queen Anne Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Beltsville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Geo	rge's place (State or Foreign
	Funeral Director		215-44-5138 1 DXM 2 T F 63 Yrs.	Months Days Hours Min.	1 (Month, Day.	Year) Cou	intry) D.C
	D		Usual Residence of Decedent		1100 29		
	srylan show	-	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits 1 ☐ Yes 2X No
	he Ma	ecto	MD Prince George's Beltsville	T			
	with t	Dir	10e. Street and Number 11406 Queen Anne Avenue	10f. Zíp Code 20705		0g. Citizen of What Cou SA	ntry?
	ms 23	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri	ican Indian,
و	or Iter		1 Never Married Married 1 X es 2 No	f Yes, specify Cuban, Mexican, Puerto I □Yes 2™ No <i>Specify:</i>	Rican, etc.)	Black, White,	etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, It e Madical Examiner must be notified at	d by	3 Widowed 4 Divorced Year or Dates: 1964-6/			Specify: Whi	
-5	n 72 h "natu	Completed	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	16b. Kind of Business/Ir	ndustry
212	withii liene. r than	mo di	Elementary/Secondary (0-12) College (1-4or 5+)	intendent	E.	ngineer/Exc	avating
	be filed within 72 hours after death with the Marylan at all Hygiene. I set Hygiene. I set the marker is the marker of the profit of a set of the went, the Marical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam			
<u>Ja</u>	should be and Mental s marked o umatic eve	70 E	Kenneth Henry Reichard	Doris Vi	rginia S	pangler	
Maryland	Ta is a		19a. Informant's Name/Relationship (Type. Print) 19b. Mailir Rebecca E. Scott/Domestic Partner 114	g Address <i>(Street and Number or Rui</i> 06 Queen Anne Ave			
ē,	Hea Hea the		20a. Method of Disposition 20b. Place of Dispo	sition (Name of natory or other place)	Date	20c. Location - City or T	own, State
altımore,				e Crematory 07/0	8/08 B	eltsville,	MD
žati	permit. Page Department Important: If any injury or once.		21. Signatore of Funeral Service Licensee	Name and Address of Facility	on Servi	ce P.O. Bo	x 784
מ	<u> </u>		Levely L. Health MO1251 B	everly L. Heckrot	te. P.A.	Clarksvil1	e. MD 21029
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
And I	Physician /Medical		resulting in death)	(m)			30 month
1	Examiner		Due to (or as so insequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	cuted nd ransit	Examiner	that initiated events				
8/60,	icate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):				
2	ficate g phys	edical	d				
XOR	eath certific attending p for use as	M/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	15		23d. Date of deliv	/ery
Ö.	deati	sician/M	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5] Ectopic pregnancy] Other <i>(sp</i> ec <i>ify)</i>		Month	Day Year
7. O	at the	Phys	9 LI Unknown				
ds,	e law requires that the death has been signed by the atter e 2 should be detached for u	þ	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.	1 Ye	pacco use contribute to t	the cause of death?
ecord	v requ	ompleted					
Ě	The law cate has the page 2 sl	dw			24a. Was at autops perforn	v prior to co	opsy findings available empletion of cause of
-	sician: The certificate rector, pag	ပို	25. Was case referred to medical	26 Plans of Deat	perform 1 □ Yes		2 □No
	Physician: this certific ral director,	0 B	examiner? 1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Othori	- 1	ence 6 ☐ Other (Speci	ify)
	ng Ph	T:UC	27. Manger of Death A Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) Injury			w injury occurred	
	Attending r death. ector: Afte by the fune	catic	2 Accident investigation	M 1 ☐Yes 2 ☐No			
	or Att after da Direct in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)	eet, factory, office	28f. Location (St City or Town	reet and Number or Rur n, State)	al Route Number,
_	spital		29a. Certifier Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place	, and due to the c	ause(s) and manner as	stated.
;	To the Hospital or Attending Physician: In 124 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	rred at the time, d	ate and place, and due	to the cause(s)
	with To t	Σ	29b. Signature and title of certifier	29c. License number	2:	9d. Date signed (Month,	_
			Ind AVatoron	V01052		Jaly 112	2008
01	1)22		30. Name and address of person who completed cause of death (Item 23a) (Type, DAV, DAV, L. VAV EX LUMB 3001 No	enover Street	, Balti	moro, Ma	-/and
	Stat	te	31. Date filed (Month, Day, Year) 32. Figistrar's Signature	Sand a			
	Registra	ar	The same of the sa	73462)			

DHMH 17 Rev 1/2001

			for State Registrar		of Marylar	nd / Depa <i>Cei</i>	artment of F rtificate of	lealth and Death	d Mental H	ygiene Reg. No		23	420
	Physici /Medic		1. Decedent's Name (First, Mid Magal Huli Ran		10				2. Date of D Month July	Death Day	2008	3. Time of 5:53	Death A M
1	Examir	er	4a. Facility Name (If not instituti Casey House Ho		number)		4b. City, Town, o Rockv		eath	4c. County of Death Montgomery			
ı	Funeral Director		5. Social Security Number 562-54-5644	6. Sex 1☑ M 2□ F	7. Age (In yrs.	last birthday) 76 Yrs.	If Under 1 Year Months Days	lin. B. Date of E. (Month, 1)	Birth Day, Year) I, I	9. Birth Cqu Ind	place (State o ptry) La	r Foreign	
	show	'n	Usual Residence of Decedent 10a. State 10b. Count	,		ty, Town or Lo					1	10d. Inside Cit	•
	ith the M or 28a-f	Directo	Maryland Mont	gomery		Rockvi	10f. Zip Code		<u> </u>	10g. Cit	izen of What Cour		2 🗆 140
	death w	Funeral	2 Trail House	12. Was De	cedent Ever in U	.S. 13. V	Vas Decedent of H f Yes, specify Cuba		(Specify Yes or N		ed State	can Indian,	
3036	ours after ral", or ite	Š	1 ☐ Never Married 2XX Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes (s 2⊠No Give		r Yes, specify Cuba	an, Mexican, Pu Specify:	ierto Hican, etc.)		Black, White, Specify: Asia		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Examirer must be rediffied at	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed College	(1-4or 5+)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of v t)	vorking		ind of Business/In		
nd 2	oe filed v tal Hygie d other t event, In	Be Co	17. Father's Name (First, Middle	, Last)	+	Engin	eer	18. Mother's N	Name (First, Midd	_	surname)	Enginee	ring
aryla	should nd Mer marke ımatic	ဥ	Magal Huli Rao 19a. Informant's Name/Relation			19b. Mailin	g Address (Street		vathi Ba Bural Boute Num			Code)	
ě,	s 1 and 2 of Health a item 27 is r other trai		Nirmala Rao /	Wife	205 5	2 Tra	il House	Ct. Ro		MD 2	.0850		
saltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once.		1 ☐ Burial 2 🌣 Cremation 4 ☐ Donation 5 ☐ other	3 ☐ Removal from	n State	thaven	sition (Name of pattern of other place of cremator)	ry Jul	y 6, 2008	Fred	ecation - City or To lerick, M	Marylan	ıd
ga	permit Depar Impor any In		21. Signature of Meral Service	e Lice ee		Re 95	Name and Address thaven 01 Catoci	Funeral tin Mtn	Service . Hwy. F	s, Sk reder	kot Cody	P.A. 21701	
4	Physician		23a. Part 1. Enter the disease, of shock, or beart failure. Lis Immediate Cause (Final			h. Do not ente						Approximate Interval Bety Onset and D	ween
	/Medical Examiner		disease or condition resulting in death)	- u.	iple Mye								
	uted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	b	o (or as a conseq	uence of):							
00/00	ificate be executed g physician and as the burial-transit	al Exal	that initiated events resulting in death) Last	c	o (or as a conseq	uence of):							
700 X		Medical	IF FEMALE:	d									
.O. BOX	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as to apply the funeral director.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna e birth 2☐ Feta gnant at time of c known	I death 3 🗆	Ectopic pregnancy Other (specify)	/		2	23d. Date of delive Month	,	ear/
cords, r	quires that en signed t uld be deta	þ	Part II. Other significant condit	ions contributing to	death but not resi	ulting in the un	derlying cause give	en in Part I.			se contribute to th		
ם בי	The law re ate has be page 2 sho	Completed							24a. Wa auto pen 1 □ Yes	opsy formed?	24b. Were auto prior to co death?	mpletion of ca	ıvailable ıuse of
7	rsician: s certific lirector,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Impetiont OF	FB/Outration	Othe		eath (Check only	one)			•
	nding Physician: The ath. r: After this certificate h. e funeral director, page	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date	Inpatient 2 e of Injury nth, Day, Year)	28b. Time of Injury	28c. Injury Work	4 L Nursing	9 Home 5 Res 28d. Describe		3 ☑ Other (Specify occurred	y) HOSP	<u>lce</u>
	tal or Atters after desal Directo	Certific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ained 28e. Plac	e of Injury - At ho ding, etc. <i>(Specif</i>	ome, farm, stre	et, factory, office		28f. Location City or To	(Street and wn, State)	d Number or Rura)	l Route Numb	per,
10	ne Hospi n 24 hour ne Funer pletely fill	Medical	29a. Certifier (Check only one) Check only 2 Medical	ng Physician: To the Examiner: On the and mar	ne best of my kne basis of examina nner stated.	wiedge, death tion and/or inv	occurred at the tin estigation, in my op	ne, date and pla pinion, death oc	ace, and due to the courred at the time	e cause(s) e, date and	and manner as s place, and due to	tated. the cause(s)	
	Vith To t	Σ	29b. Signature and title of certified	ie lik	10		29c. License D 006				e signed (Month, 2008		
	6		30. Name and address of person Genevieve Wrob				r _{int)} aster Mil	1 Rd. T	Rockvill	e, MTN	20855		
	Stat Registra	-	31. Date filed (Month, Day, Year)		gistrar's Signat	B Ap	ale			-,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Donartment of Health

10			For State Registrar	state of Maryland /		rtment of H tificate of L		ientai Hygi Re	ene 2008	23421
	Physici	ian	1. Decedent's Name (First, Middle, Last)	Tro				2. Date of Death Month	Dav Year	3. Time of Death
	/Medi Examir		John C. Spahr, 4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of Death	July :	16 2008 4c. County of Deat	4:10 A.M
	2	Н	College View Cent			Freder			Frederi	
	Funeral Director		5. Social Security Number 6. Sex 115 M 219-66-3771 Usual Residence of Decedent	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01/26/1	Year) 9. Birt 954 Mar	hplace (State or Foreign untry) yland
	ryland how		10a. State 10b. County	10c. City, Tov						10d. Inside City Limits
	he Ma 28a-f s	Director	Maryland Howard 10e. Street and Number	Woo	odbii					1 ☐ Yes 2 M No
	3a or		7255 Woodbine Roa	ad		10f. Zip Code 21	.797		og. Citizen of What Co United Sta	,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Experience is use be notified at once.	Completed by Funeral	11. Marital Status 12. Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2½ No If Yes, Give Ye ar or Dates:		/as Decedent of His Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto		14. Race - Ame Black, White	rican Indian,
15-(n 72 h "natu «dical	letec	15. Decedent's Educati (Specify only highest grade co	on 16a ompleted)	a. Deced	ent's Usual Occupa	ation uring most of working	ng 1	6b. Kind of Business/	ndustry
212	d withii giene. ir than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		technicia			electroni	CS
	be filed tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		aiden Surname)	
Maryland	hould id Men marke matic	မ	John Curtis Spahr		h Mailine	Address (Ctrast o	Zelma	Burrier	City or Town, State, 2	
, Ma	and 2 sealth ar		Robin Schlegel/ sis						MD 21704	ip Code)
Baltimore,	Pages 1 ament of He lant: If item		20a. Method of Disposition	Restha	aven		dens 07/1	.8/08	Oc. Location - City or Frederick,	MD
Ball	permit Depart Import any In		21. Signature of Funeral Service Licenses	nck_M01222					sford Fune rick, MD 2	
80'0	Physician and /Medical Examiner as the prival-transit	Examiner	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of the complex cause. (Final disease or condition resulting in death) Sequentially list conditions, a. — Sequentially list conditions, b. — cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	7: of):		y, such as cardiac c		st,	Approximate Interval Between Onset and Death
68760,	ficate be physici s the bu	edical	d							
P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as to	Physician/Me	in the past 12 months?	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	w requires that been signed should be det	þ	Part II. Other significant conditions contrib	uting to death but not resulting i	in the und	derlying cause giver	n in Part !.	23e. Did toba	acco use contribute to	the cause of death?
tal Records,		Completed	25. Was case referred to medical					24a. Was an autopsy perform	ed? prior to death? 1 □ Yes	topsy findings available completion of cause of 2 □ No
<u> </u>	Physician: this certific al director, I	lo Be	examiner? 1 Yes 2 16	ital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient	Other	26. Place of Death	•	nce 6 □ Other (Spec	nify)
o uo	Attending Physician: or death. ector: After this certific by the funeral director.	tion: 1	27. Manner of Death 1	8a. Date of Injury 28b.	Time of Injury	28c. Injury Work?	at 2	8d. Describe how		ny)
Division of Vital	r ii fe	Certification: To	3 Suicide 6 Could not be	8e. Place of Injury - At home, fa building, etc. <i>(Specify)</i>	arm, stree			8f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital of within 24 hours a To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 12 Certifying Physicia 2 Medical Examiner:	an: To the best of my knowledg On the basis of examination a and manner stated.	e, death nd/or inve	occurred at the time estigation, in my opi	e, date and place, a inion, death occurre	and due to the cared at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	_		29c. License	number		d. Date signed (Month	
	.\		30. Name and address of person who compl	eted cause of death (Item 23a)	(Type D	D 60	2417	'フ	-16-0	× 13
	H		Hemen Shah	65-C The	O MC	1	nson I	Y F	-16-03	21702 MD
i	Sta Registra		31. Date filed (Month, Day, Year) JUL 2 1 2008	. Registrar's Signature	Green	e de la companya della companya della companya de la companya dell			•	

Registrar DHMH 17 Rev 1/2001 William Louis Schendel

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		egistrar		Certificate (or Death			eg. No.				
Physiciar Medical Examin	1/											
	ľ	a. Facility Name (if not institution, on 10702 National Pike	give street and number)		4b. City, Town, Clear Spri	or Location of Deat	Pool	4c. County of De Washington				
Funeral Director	1		Sex 7. Age (In 57	yrs. last birthday)	If Under 1 Y Months D	ear If Under 24Hr ays Hours Mi	s. 8. Date of Bir n. 8 – 26 –	1950	Birthplace (State or Foreign Country) Michigan			
		Usual Residence of Decedent	1400	City Tayer on Lon	otion				10d. Inside City Limits			
Maryland 28a-f show any <u>1 at once.</u>			ngton	. City, Town or Loc Big Po	ol				1 Yes 2 XNo			
tith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10702 Nation	nal Pike		10f. Zip Code		1	0g. Citizen of What C U . S . A				
with the		11. Marital Status	12. Was Decedent Eve	r in U.S. 13. V		Hispanic Origin? (\$	Specify Yes or No	- 14. Race - An	nerican Indian, Black,			
<u>ਵੰ ਦੰਗ</u> ੀ	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorce	Armed Forces? 1 Yes 2 X ted If Yes, Give Year or Dates:	No	Yes, specify Cub	oan, Mexican, Puerl	to Rican, etc.)	White, etc Specify: Wh				
67	Completed b	15. Decedent's Education (Specify Elementary/Secondary (0-12) 12th grade	college (1-4 or 5+)	during		pation (Give kind of ife. DO NOT use re		auto m				
15-0(filed wi Hygier d other	<u></u>	17. Father's Name (First, Middle, La Norman Louis	Schendel					Maiden Surname) Osenberr	У			
MD 2121 d 2 should be fi Ith and Mental n 27 is marked nummatic event,	2	19a. Informant's Name/Relationship Donald Rosen	(Type, Print)brothe	er 19b. Mail				nber, City or Town, S r Spring	tate, Zip Code) , MD 21722			
ore, stan of Hea If iter	- 1	20a. Method of Disposition 1 Burial 2 X Cremation		20h Place of Disc	osition (Name of		Date		y or Town, State			
Balt permit. Depart Import injury	-	Donation 5 Other Special Service Lie 23. Part Lighter the disease, or co	censee Fierel	22 IP	Name and Addr Donald	ess of Facility Edwin T	hompso	n Funera ing, MD	l Home, Inc 21722			
Physician 'Medical .xaminer		failute. List only one cause on Immediate Cause (Final disease or condition resulting in death)	a. Contact Gunshot V	Vound of Head					Between Onset and Death			
	<u>ner</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b	ence of):								
	ΞĮ.	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):								
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Box 68760, e death certificate by the attending physic ed for use as the bur		IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcome of Live birth 4 Pregnant at time 9 Unknown	2	Fetal death Other (Specify)	3 Ectopic preg	nancy	23d. Date of deli Month	ivery Day Year			
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ital Recicion: The Secrificate	å	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/Outpatie		Other: Nurs	sing Home 5	Residence 6 🗸	Other: Scene			
n of Viding Physi	음	1 ✓ Yes 2 No 27, Manner of Death	28a. Date of Injury	28b. Time o		njury at Work?	28d. Describe	how injury occurred				
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should have in the funeral director, page 2 should have been seled in by the funeral director, page 2 should have the funeral director, page 2 should have been seled in the funeral director, page 2 should have been seled in the funeral director, page 2 should have been seled in the funeral director bear at	ation	1 Natural 5 Pendin 2 Accident Investig	ation	0000 hrs	1	Yes 2 V No	Subject sho					
Divis Hospital or At 24 hours after d Funeral Direc	Certification:	3 Suicide 6 Could r 4 Homicide determ			treet, factory, offic	ce building, etc.	or Town, 1 10702 Nation	State) Bio Po	r Rural Route Number, City O I MD			
	<u>ल</u>	29a. Certifier 1 Certifying Physical Cone) Certifying Physical Exami	sician: To the best of my kn iner:On the basis of examina and manner stated.	owledge, death oc ation and/or investi	gation, in my opir	nion, death occurre	nd due to the cau d at the time, date	and place, and due	to the cause(s)			
	Σĺ	29b. Signature and title of certifier	Halla			ense number C.M.E.		July 13, 2008	(Month, Day, Year)			
	ľ	30. Name and address of person w Carol Allan, MD Assis	no completed cause of death stant Medical Examin		n Street, Balt	imore, MD 212	201					
Sta Registr		31. Date filed (Month, Day, Year)	2008 32. degistrar's S	200	ne							
		2	OCME	6								

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician 2008 9:30 A M Frances Ann Santoriello 3Ō°. /Medical June 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1313 Harmony Lane Annapolis 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days 1 □ M 2 🖾 F 183-24-6299 Director Oct. 4, 1931 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examinating the notified at Director MD Anne Arundel 1 ☐ Yes 2 TX No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1313 Harmony Lane 21409 USA Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. White þ Specify 3 Widowed 4 Divorced than "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Arcuri Clara Spena 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Santoriello/Husband 1313 Harmony Lane Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 3, 20c. Location - City or Town, State 1 Ma Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial 4 Donation 5 Dother (Specify) Annapolis, MD 2008 21. Signature of Funeral Service License 22. Name and Address of Facility Paranco & Sons, 495 Gov. Ritchie Severna Park Funeral Home Severna Park, MD 21146 Hwy. fart 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between medial Cause (Final diseas r condition resumg in death) **Physician** Mulmon COY CAY /Medical Due (or as a consequence of): Examiner MOUANL Sequentially list conditions, is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and siely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Tyes 2 TNo g Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 2 🗆 No 2010 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐ 1\no Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Pesidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 🗆 No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca (Check only 29b. Signature and title of certifie nd address of person who completed cause of death (Item 23a) (Type, Print) 5 31. Date filed (Month, Day, Year) State 3 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

Physician (Medical Examiler) As. Facility Name (if not institution, give street and number) Doctor's Community Hospital Funeral Director Funeral Directo			For State Registrar			Certificate of		Re	eg. No.			
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The State Part of the Country of the												
Prince George's 100. College Park 100. C			213-16-2635			Months Day		8. Date of Birth (Month, Day, June 7,	9. Bir 1919 Mary	thplace (State or Foreign ountry) 11and		
To pure the purpose of the purpose o	ryland how		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits		
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Physician Medical Examiner Notice Septiment of the septi	L21	ပ်	6		Pai	nter/Carpe	7			on		
Physician //Medical Examiner 23a. Part I. Enter the desse, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Physician (Nedical Examiner) (Nedical Examiner) 25a. Part I. Enter the desse, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Physician International Cause) (Nedical Examiner) (Nedical E	anc ancertain the first of the	B		_ast)				•	·			
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Physician Medical Examiner Ph	Ball permit Depart Import	ouce	21. Signature of Funeral Service L	icensee the	MO1251	22. Name and Add Going Hom Beverly L	ress of Facility e Crematio . Heckroti	on Servic	e P.O. Bo	ox 784		
Prysician (Medical Examiner) Prysician (Medical Examiner)			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each li	the death. Do no					Approximate Interval Between		
Due to (or as a consequence of): Sequentially ist conditions, if any, less are 15 limits distinct to the cause of the conditions of the		_	disease or condition	<u>Se</u>	PSi's					Oriset and Death		
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1 ten Home 165909 2/2/08	To the vithin To the somple	Me	29b. Signature and title of certifier			29c. Licer	nse number	29	9d. Date signed (Mont	h, Day, Year)		
(1+) as 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fosil B. Otemu, mD 8118600d/uckRd., Lanham, mD. 20706			1 fair	Hem	_1	DO	05909		7/3/	08		
	(H)az		30. Name an address of person w	who completed cause of d	leath (Item 23a) (T 18 600d	ype, Print) Luck Rcl.	Lanh	iam, m	D. 2070	6		
State State State Flied (Month, Day, Year) 32. Figistrar's Signature State Registrar			31. Date filed (Month, Day, Year)	2000 32. 2 gistra	ar's Signature	1.0.	/					

Registrar
DHMH 17 Rev 1/2001

			for State Registrar	State o	of Marylar		artment of H		nd Mental Hy	giene ,	2008	23425			
	Physici	ian	1. Decedent's Name (First, Middle David H. Soule	e, Last)					2. Date of De Month	riog. Ito.		3. Time of Death			
mark.	/Medi		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, or	Location of D		4c. C	8:10 A M				
A.F.			16820 Oak Hill				Silver S	_			ntgomery				
	uneral irector		5. Social Security Number 362-24-6868 Usual Residence of Decedent	6. Sex 1 X M 2 □ F	7. Age (In yrs.		If Under 1 Year Months Days		Min. 8. Date of Bir (Month, Dir Feb 24	th ay, Year) 1923	9. Birthp Coun Michi	lace (State or Foreign try) gan			
ryland	how #		10a. State 10b. County		10c, Cit	ty, Town or Lo	cation				10	0d. Inside City Limits			
he Ma	28a-f s	Director	MD Montgor	nery	Silv	ver Spr						1 □ Yes 2 🖾 No			
with t	3a or 3	ä	10e. Street and Number 16820 Oak Hill	Road			10f. Zip Code 20905			10g. Citize JSA	n of What Coun	try?			
5 fter death	r items 2	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Dece	edent Ever in U.	.S. 13.		spanic Origin n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)		. Race - Americ Black, White, e				
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/lan	marked other than	To Be	17. Father's Name (First, Middle, Last) Byron Avery Soule 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Houghton												
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To the Hospital or Attendin within 24 hours after death.	Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									Route Number,			
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To the within	To the		29b. Signature and title of certifier	and mann	er stated.		29c. License				igned (Month, D				
L	0		30. Name and address of person w	to completed cause	of death (Item	23a) (Type P	DOO rint)	6319	6	7/7	08	2000-			
(12)	12		Yatthew C.	MAU	drew	13	55 Picco	rvel ?	Srive &	Locki	ille. 1	20850 D			
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			For State	State of Maryland					_	2000	20120
		-	Registrar 1. Decedent's Name (First, Middle, Last	A)	Cei	tificate of	Death	2. Date of De		2008	2 3 4 2 5 3. Time of Death
	Physici	ian	Kenneth Robert					Month	Day	Year	
	/Medi		4a. Facility Name (If not institution, give			4b. City. Town. o	or Location of Death	July		2008 County of Death	$4:30 \text{ A}^{\text{M}}$
	Examir	ner	404 Braddock Av		i		erick			Frederi	ick
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th		place (State or Foreign
. 9	Director		262-23-5750	2 M 2□F 5	1 Yrs.	Months Days	Hours Min.			56 Penr	isylvania
	pu. »		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation					0d. Inside City Limits
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	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Ex miner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	. 13. \	Vas Decedent of H	lispanic Origin? (Si	pecify Yes or No		4. Race - Americ	an Indian,
9	after or Ite	Ē	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give		r Yes, speciny Cub I∐ Ye <i>s 2</i> 127 No	an, Mexican, Puert	o Hican, etc.)		Black, White,	
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	filed Hygi ther sht, tl	ပ္မ	17. Father's Name (First, Middle, Last)			- pontol	18. Mother's Nam	ne (First, Middle,			
an	id be ental ked o	To Be	Leonard Schatz	Jr.			Edith A			uni	•
Maryland	shou and M s mar umat	-	19a. Informant's Name/Relationship (7)		19b. Mailin	g Address (Street	and Number or Ru		er, City or	Town, State, Zip	Code)
	and 2 ralth a 27 is er train		Jody Schatz / W	Vife	404	Braddoo	ek Ave.	Freder	ick.	MD 21	701
Ore	of He filter		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 】		ice of Dispo metery, cren	sition (Name of natory or other pla			20c. Loc	ation - City or To	own, State
<u>ï</u>	Pages ment of I ant: If Ite		4 □ Donation 5 □ Other (Specify)		haven	Cremato		3,2008	Fred	derick,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Exeminer must be notified at once.		21. Signature of Funeral Service License	ee	Re 95	Name and Address thaver	ess of Facility Tunera	l Servi	ces,	Skkot	Cody P.A. MD 2170
	1		23a. Part1. Enter the dise of or composhock, or he of failure. List only o	lications that caused the death.	Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	ierrek,	Approximate Interval Between
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7	/Medical		resulting in death)	a. Due to (or as a conseque						/	2110111
20	Examiner		Sequentially list conditions	b							
	g is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	anice of):						
	and and I-tran	хаш	that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):						
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	ficate phys s the	edical		d							
Вох	The law requires that the death certific tte has been signed by the attending p tage 2 should be detached for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnan					2:	3d. Date of delive	erv
ĕ	death a atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea		lEctopic pregnanc Other <i>(specify)</i> _	у			Month	Day Year
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s, P	res tha igned be del	by P	Part II. Other significant conditions co	ntributing to death but not result	ting in the ur	nderlying cause giv	ven in Part I.	23e. Did to		A	he cause of death?
Records,	w require been signature					1		1 🗆 '	Yes 2	¶No 3□ Prot	ably 4 □Unknown
ecc	ne law r has be ge 2 sh	Completed						24a. Was autor		24b. Were auto	ppsy findings available mpletion of cause of
<u> </u>		P P						perfo 1∐ Yes	rmed? 2 ⊭ No	death?	2 No
Vital	ysiclan: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?	I I Va-I			26. Place of Dea	th (Check only o	ne)		
or \		မ	1 163 4740		R/Outpatien		4 🗆 Ruising n			□Other (Special	ý)
n	ling After fune	ion:	27. Manner of Death 1 ★Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	ryat rk? Yes 2∐No	28d. Describe I	now injury	occurred	
Division or	Attending r death. ector: After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At hom	ne. farm. str		1 res 2 110	28f Location /	Street and	Number or Rus	al Route Number
Σ	after after Dire	ertii	3 Suicide 5 Could not be determined 4 Homicide 4 Homicide 5 Could not be determined 5 Could not be determined 5 Could not be determined 6 City or Town, State) 28f. Location (Street and Number or Richtstein City or Town, State)								
	To the Hospital or Attending Ph within Z4 hours after death. To the F4 hours all Director: After the completely filled in by the funeral		29a. Certifier 1/2 Gertifying Phy	sician: To the best of my know	ledge, death	occurred at the ti	me, date and place	, and due to the	cause(s)	and manner as s	stated.
	he He in 24 he Ft	Medical	(Check only 2/ Medical Examone)	iner: On the basis of examination and manner stated.	on and/or in			rred at the time,	date and	place, and due t	o the cause(s)
	With Com	Σ	29b. Signature and title of certifier	9/2 D 10	0	29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
			b Whered.	Correct, M		40 .	0.70/		11	0/200	σ
U	+IVr.		30. Name end address of person who co	ompleted cause of death (Item 2	23a) (Type,	Print)	ACTIVI ST	FREE	1600	K MI	21701
		ate.	31 Date filed (Month Day Year)	32 Redistrar's Signatu	ire.	1 4-	NTA ST.	7 4EK)	da	1	1 4/01
	Sta Registi		JUL 08	2008 Malue	B. A	porte		,		/	

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 9:40 AM /Medical Mabell Sample 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Salisburg Rehab + Nursing Ctr Social Security Number 6. Sex 7. Age (In yrs. Ast birthda Wicomico If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF Director 67 Nov. 6, 1940 Virginia 140-34-3516 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 809 Mohawk Avenue 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ltimore, Maryland 21215-Food Service Elementary/Secondary (0-12) College (1-4or 5+) 10 laborer Salisbury University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be file tment of Health and Mental H tant: If Item 27 Is marked oth Be Robert Lynn Jones Louise Banks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Decatur Avenue - Salisbury, Maryland 21804 Robert L. Sample/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Mem. Gdns July 10, 2008 Hebron, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD JOLLEY MEMORIAL CHAPEL, P.A. 21801 23a. Part1. Enter the disease, or complications that caused le death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one gause on each light. Immediate Cause (Final disease or condition resulting in death) **Physician** land e /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1□ Yes 2 3 No Physician; 25. Was case referred to medical examiner? director Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 4 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident hin 24 hours after deati the Funeral Director; 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 7 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MD Robins, M.D.
32. Registrar's Signature William H. 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of N	Maryland	d / Depa	artment of I	Health and I	Mental Hy	giene 2	008	23	428	
	Dii		1. Decedent's Name (First, Midd	lie, Last)					2. Date of De			3. Time of	Death	
	Physic /Medi		Margaret	VanderI	Bogart		Stone		Month 7	Day 6	Year 2008	7:45	Ам	
Mary.	Exami		4a. Facility Name (If not institution	on, give street and numbe	r)		4b. City, Town, o	or Location of Death		4c. Cour	4c. County of Death			
			Sunrise Assist	ed Living		Severna	Park		Anne	Arund	e1			
	Funeral		5. Social Security Number		Age (In yrs. la		If Under 1 Year Months Days		8. Date of Birt (Month, Da			lace (State o	or Foreign	
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036	al", o	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes Give			1∐Yes 2 X ∏No	Specify:		Spec	ify: Whi	te		
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yla	d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. 77 is marked other than "natural"; or items 23a or 28a-f show traumatic event, the Modical Exeminating the notified at	2	Hugh Jac	kson	Vander	Bogar	t	Dorothy		1	Porter			
ar	2 sho and is m		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Numbe	er, City or Tow	n, State, Zip	Code)		
2	ss 1 and 2 of Health a item 27 is other trai		Dorothy Elder -	- Daughter				St., Ann	apolis,	MD 214	101			
ore	Pages 1 nent of H ant: If iter ary or ott		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation	2 Pamoual from State	20b. Pla	ace of Dispo metery, cren	sition (Name of natory or other plac	ce)	Date	20c. Location	a - City or To	wn, State		
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<u>S</u>	death. ctor: A: / the fu	äţi	2 ☐ Accident investig	ation	y, rear)	ii gai y		Yes 2 □No						
The state of the s									28f. Location (Si City or Town	treet and Num	ber or Rural	Route Numb	per,	
	ral D									,			()	
2 Accident 3 Suicide 4 Homicide Specify Street are continued one) Specific part of the par									ause(s) and r	nanner as st	ated.			
1	within 2 To the comple	Med		and manner st	ated.									
, i	≥ ≥ 8		29b. Signature and title of certifier	: Cast	MA		29c. License	K297	2	9d. Date sign	ed (Month, D	100th, Day, Year) 7, 2008 K-M021146		
		-	- Julia		F + 0		104	0211		July	1,	2008		
//	Onef		30. Name and address of person of Elaine Av	J	leath (Item 2	3a) (Type, P	rint)	2 00 1	50.10	. 0	- V	111	114/	
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	Registra		JUL 0 9	2008	ar's Signatur	f	ME					-4		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Lest) 3. Time of Death Day Year Lynn Elaine Taylor 0737 M June 2008 30 4a, Facility Name (If not institution, give street and number)
4b. City, Town, or Location of SCAINSULA Relational Medical (Inter Scales Dun) 4c. County of Death 4b. City, Town, or Location of Death

/Medical Examiner

Physician

			Keninsula			dicil	Center	Salis	buny		W	1 CON		
	uneral		5. Social Security Num 220-52-23		Sex 1□M 2□F		s. last birthday Yrs.	Months Days	If Under 24 Hours	Min. (Month, L	Day, Year)		hplace (State or Foreign untry)	
	irector		Usual Residence of De			59_				03-26-	-1949	Mai	ryland	
ryland	how	_	10a. State	0b. County		10c. C	City, Town or L	ocation					10d. Inside City Limits	
le Ma	8a-fs	Director		Somerse	t		Chance			.,,			1 XYes 2 □ No	
with th	a or 2		10e. Street and Number		Daad			10f. Zip Code			10g. Citizen o		untry?	
eath	IIS 23	Funeral	10694 Toddville Road 21821 11. Marital Status 21. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hisp If Yes, specify Cuban,							n? (Specify Yes or N	o- 14. R	USA 14. Race - American Indian,		
6 after o	or ite		1 ☐ Never Married	2 Married	Armed For 1 ☐ Yes	ces? 2 No				Puerto Rican, etc.)		Black, White, etc.		
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Husiene	or reading any wenter mygeries. The most state of \$8a-f show them 21s marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventing and the mytthnose.	Completed	Elementary/Seconda	ary (0-12)	College (1 none	4or 5+)		memaker	(0)		Own Ho	me		
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/lar	arked atic ev	To E	Lawrence	C. Dav	is				Eliza	beth Mere	dith			
Taryla 2 should	is me		19a. Informant's Name	e/Relationship	(Type. Print)		19b. Mail	ng Address (Street	and Number	or Rural Route Num	ber, City or Tow	ın, State, Z	Tip Code)	
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_• 8	signed by the a	ysic	1 ☐ Yes 2 ☑ N 9 ☐ Unknown	io	4 ☐ Pregn 9 ☐ Unkno	ant at time of wn	death 5	Other (specify) _					,	
IS, P.O	ned by		Part II. Other significa	int conditions	contributing to de	ath but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ontribute to	the cause of death?	
rds quires	an sig	ed by						÷		1□	Yes 2 No	3□ Pro	obably 4 ☐ Unknown	
I HECOLO The law requi	as be	plet								24a. Was	s an 24l	o. Were au	topsy findings available completion of cause of	
r e	page	Completed								perf 1 □ Yes	ormed2	death?	2 □No	
VITAI H	ector,	Be	25. Was case referred examiner?		Hospital			I ou	~	f Death (Check only	one)			
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VISI Atter	by the	ifica		6 Could not b	Zoe, Flace	of Injury - At I	nome, farm, st	reet, factory, office		28f. Location		mber or Ru	ral Route Number,	
tal or	al Dir	Certification:	4 El Tiomicide		Dallall	g, etc. (Spec				City or 10	iwn, State)			
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: After this certificate has been sompletely filled in by the funeral director, page 2 should	edical	29a. Certifier (Check only one)	Certifying Pl	miner: On the ba	sis of examir	nowledge, dea nation and/or in	th occurred at the to estigation, in my	me, date and opinion, death	place, and due to the occurred at the time	e cause(s) and , date and plac	manner as e, and due	s stated. to the cause(s)	
To the	ro the	Mec	29b. Signature and title	e of certifier	and mann	oi stateu.		29c. Licens	se number	I	29d. Date sign	ed (Month	n, Day, Year)	
_ >	- 0			\supset				Mn	00660	198	6 38	08		
		-	30. Name and address	of person who	completed cause	of death (Ite	m 23a) (Type,			10	1.	1		
5	EB		Justinia			Astrar's Sign		East Co	lorm	St S	Salisbu	m ,	MD 51204	
١	Stat		31. Date filed (Month, I											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - State Registrar 23430 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 2:00 AM 2008 von /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Worcester HOSOItal
7. Age (Ih yrs. last birthday) If Under 24 Hrs. Min. zeneva! Birthplace (State or Foreign Country) 5. Social Security Number 181-52-8885 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 X F Months Days 50 7 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits 10b County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f show event, its Medical Examiner must be notified at 1XYes 2 □ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 19320 South USA Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) m 27 is marked other than "r. er traumatic event Elementary/Secondary (0-12) College (1-4or 5+) VC55CV 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roosevelt heodove 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Mark Department of Health Important: If item 27 any Injury or other to once. von 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/08/08 West Chester erris + Co. Inc. 07/08/0 22. Name and Address of Facility 5+rano + Feeley Family 635 Churchmans Road 19702 Rodd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** (1' Who sis Hepatic disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy performed?

1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Sonhacht Reverly 81-52-8885 Division of Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

100:0200

31. Date filed (Month, Day, Year) JUL 0 7 2008

29b. Signature and title of certifier

Atif Zees han

9733 Houlth Way Drive AaH Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1)0064120

29d. Date signed (Month, Day, Year)

Berlin MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 11:41 A M **JAMES** WILCOM MICHAEL /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Oct 20, Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Mary Land 220-30-9140 Director 72 Usual Residence of Decedent 10c. City. Town or Luca... Monrovia 10b. County Frederick State Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at Maryland Director 1XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21770 4303 Green Valley Road Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ Nd 1955-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1963 1 ☐Yes 2 No Specify: White 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur. any injury or other traumatic event, the Medicul E ODGE. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farming Agriculture 17. Father's Name *(First, Middle, Last)* **Charles Francis** 18. Mother's Name (First, Middle, Maiden Surname) Be Wilcom Catherine Murphy ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 166, Monrovia, Maryland 21770-0166 19a. Informant's Name/Relationship (Type. Print) Mrs. Evelyn Wilcom, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem Gardens JUl 17, 2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Acens Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00706 Immediate Cause (Final ASSYTOLE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Disease (Right Cornery Artery) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-transit Preumonia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, domonas Physician/Medical IF FEMALE if yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar MD

22. Registrar's Signature

920

San

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D66166

400 West Seventh Street, Frederick, Maryland 21701

08

08-05405 Clyde Stebbins Wisner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 23432

			1- For State Certificate of Death Reg. No.								-	0 3111				
	hysicia	ın/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 4. Modth Day Year									3. Time of Dea 0827 hrs				
e^	Exami		Clyde Stebbins Wisner July 14, 2008 Use 14a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death													
			4a. Facility Name (if not institute 3880 Punch Island Ro	"	Taylors Island						Dorchester					
F	uneral		5. Social Security Number	6. Sex	7. Age	e (In yrs. last l	birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of Birth	(MM/DD/Y	YYY) g. B	irthplace (State or	, T
	rector		223-56-9170	1 M	2 F	65	Yrs.	Months	Days	Hours	Min.	6/26	/1943	Fore C	ountry)Oklał	10ma
		H	Usual Residence of Decedent	ual Residence of Decedent												
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and	show	5	Maryland Dorchester Taylors Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country:												No	
Maryl	or 28a-f show any fied at once.	Director												untry?		
h the	23a or notifie											JSA erican Indian, Blad	ck			
ith wi	or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status1 Never Married 2 No.	arried	. Was Decedent Armed Forces?		If Ye	es, specify	Cuban, I	Mexican, I	Puerto Ri	ican, etc.)		White, etc.	Allouin Illustria, Elec	
ter de	, or i		3 Widowed 4 Dir	vorced If Ye	s, Give Year	No	1	Yes 2	/ No	specify:			Spe	ecify:	White	
ursaf	'natural", Examiner	d b	15. Decedent's Education (Spe	L QT L)ates:	npleted) 16	Sa. Decedent	's Usual C					16b. Kind	of Business	3/Industry	
72 hc	un "os cal Ex	Completed	Elementary/Secondary (0-12)		College (1-4 or s	5+)	during me					٥,			1.5	
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AD 21215-0036 2 should be filed within 72 hours after death with the Maryland	d Mental Hygiene. s marked other than " iic event, the Medical J		17. Father's Name (First, Middle		Tibbetts '	Wiener			"	D.IVIOUTOT 3	, realine (i			Stebbin	C	
212	Mental marked ic event,	o Be	19a. Informant's Name/Relation			VV 1511C1	19b. Mailing	Address	(Street	and Numb	per or Ru	ral Route Numb	per, City o	r Town, Sta	ite, Zip Code)	- 1
MD d 2 sho	lealth and tem 27 is traumati	7	Ann T.	Wisner	r/Wife				1687	Garet	t Rd.	, Manche	ster. N	MD 21	102	
	of Health If item 2 ther traus		20a. Method of Disposition 1 Burial 2 Crematic	- 2 🗆 [Domousi from St		ce of Disposi matory or oth		e of cem	etery,		Date	20c. Loca	ation - City	or Town, State	
Baltimore,	ent of H		Burial 2 Crematic		removal from St	Mid	Shore C	remat	ion C	enter	7/1	7/2008		Camb	ridge, MD	
Balti emit	Department of Important: injury or otl		2 Signature of Funeral Service	Licensee	0			ame and		•						
			Mid Shore Cremation Center, 2272 Hudson Rd., Cambridge Mid Shore Cremation Center, 2272 Hudson Rd., Cambridge (23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Applications are complications.											bridge, MD Approximate		
	sician ledical		failure. List only one caus	e on each li	ine.		o not enter tr	ie mode o	r uyirig, s	don as ca	a diac or	roopii atory arro	or, orroom,		Between Or Dea	nset and
	miner		Immediate Cause (Final diseas or condition resulting in death)		aoral gunsho to (or as a cons				_							
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Box 68	attending for use as	ciar	past 12 months?	4		t time of deat	h	her (Spec								
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ord ord	has been s	Completed										autop		prior death	to completion of on?	cause of
Rec	cate h	Com	1 ✓ Yes 2 No 1 ✓ Yes										Yes 2	No		
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	within 24 hours after To the Funeral Directory completely filled in b	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)									-)				
		Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, You Declared to Company) 29d. Date signed (Month, D								, 20,,,,00,	,				
	,		aunn	N		death (Item C	23.2)									
a	+1		30. Name and address of personal Zabiullah Ali, M.D.		npleted cause of Int Medical E		111 Per	nn Stree	et, Balti	imore, l	MD 21	201				
'	S	tate	31. Date filed (Month, Day, Yea		2. Registr	ar's Signature	Areal	20								
	Regis		JUL 2 1	טטט'	Alexan	all'										

Registrar

State

DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			_ For	Type or Print in State of Maryla				-		egible.	
			1 - State Registrar		Ce	rtificate of	Death		eg. No. 2	008	23434
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) Elizabeth Ann	n Wood				2. Date of Dea Month June	Day 9	2008	3. Time of Death 5:30 PM
	Examir	ıer	4a. Facility Name (If not institution, give s	street and number)		Lothia	r Location of Death			ounty of Death	ו ב לה תנו
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day	1	nne Ar	lace (State or Foreign
Portion.	Director		217-30-2219 Usual Residence of Decedent	JW ZESF	74 ^{Yrs.}	54,6	1 1 1	Feb.8,			ington,DC
	ryland how at		10a. State 10b. County	10c. C	ity, Town or Lo	ocation			_	10	0d. Inside City Limits
	he Ma 8a-fs	Director	MD Anne Ai	rundel Lo	thian						1 ∐Yes 2 X∏X lo
	with the sa or 2 the m	Dir	10e. Street and Number 324 Ella Drive			10f. Zip Code		1	l0g. Citizeı	n of What Coun	try?
	death	Funeral		12. Was Decedent Ever in U	J.S. 13.	Was Decedent of F	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-		Race - America	
980	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show inth, the Medical Examiner must be notified at		1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		ir Yes, specify Cub. 1 ☐ Yes 2 【XNo	Specify:	Hican, etc.)	Sį	Black, White, e pecify: Whi	
21215-0036	be filed within 72 ho ntal Hygiene. ed other than "natuu event, the Medical	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	ı (Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working	ng	16b. Kind	of Business/Ind	lustry
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ary	and s m	-	19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Street	and Number or Rura				
	s 1 and 2 of Health item 27 I		Harry K. Farmer		4018	Bluebin	rd Dr. Wa				
nore	8 4 = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emovar nom State		sition (Name of matory or other place				tion - City or To	•
Baltimore,	- F # F		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		inity	Mem.Gro Name and Addre	dns. 13,	2008 1	Wald	orf, M	D 7
ä	permi Depar Impor any fr		Heren 18th	MOO MOO	641 56	535 Wash	nington A	Ave.La	Pla	.servi ta,MD	20646
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea ne cause on each line.	th. Do not en	er the mode of dyir	ng, such as cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Lung Can Due to (or as a conse						4	Years
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<u>α</u>	requires that the een signed by the	by Pr	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to th	e cause of death?
Records,	w require been sig should t	ted						1 🗆 Y	es 2 🗆 l	No 3 rob	ably 4 □Unknown
3ec	e faw has b e 2 sh	Completed						24a. Was a autops perfor	SV	prior to con	osy findings available npletion of cause of
ta			25. Was case referred to medical				OO Plant of Death	1∐ Yes	2 ₽ No	death? 1 ☐ Yes	2 No
or Vital	ys dir	To Be	examiner?	lospital: 1 🗌 Inpatient 2 🗀] ER/Outpatier	it 3 DOA Oth	er: 4 ☐ Nursing Hor			Other (Specify	·)
0 U	Ing Ph		27. Manner of Death XXNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	y at 2 k?	28d. Describe ho			·
Division	Attending r death. ector: After by the fune	ficati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At h	ome, farm, str		Yes 2 □No	P8f Location /S	reet and N	lumber or Rura	I Route Number,
É	s after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Speci		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	n, State)	rannoch of flara	Triodic Hambor,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	n occurred at the tir vestigation, in my o	me, date and place, a opinion, death occurr	and due to the c ed at the time, c	ause(s) an late and pl	d manner as st ace, and due to	ated. the cause(s)
	To the within 24	Ž	29b. Signature and title of certifier	1 4.5		29c. Licens	e number	2	-	igned (Month, I	
			Althou	w MI)		D462	46		Jun	- 192	2008
			30. Name and address of person who co	u. M.D. 10	St. Pa	trick's	Drive #	408 Wa	ldor	f. MD	20603
750	Sta		31. Date filed (Month, Day, Year)	32. Register's Sign	ature	Rose .					
DHI	Registr MH 17 Rev 1/20		JUL & I	LOUD PARTERIAS.	1 15	MARKE					
J. 111	1104 1/20										

Division of Vital

State

Registrar

2

3

4

Medical

Accident

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

30. Name and address of person who completed Guse of Jah (Item 23a) Assistant Medical Examiner Theodore M. King, Jr., MD. 31. Date filed (Month, Day Year) trar's Signature

and manner stated

Pending

Investigation

Could not be

determined

111 Penn Street, Baltimore, MD 21201

Yes 2 No

28f. Location (Street and Number or Rural Route Number, City

July 1, 2008

29d. Date signed (Month, Day, Year)

or Town, State)

OCME

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend istate 18 Maryland 8882 25-08 Mealth and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) YERS **Physician** EVEN 21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Chesapeake Hospice House Anne Arundel Linthicum Heights 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Nov 7, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 5. Social Security Number **Funeral** Hours Days Min 1 2 M 2 F 58 Of Columbia 1949 Director 218-58**-1**675 Nov Usual Residence of Decedent 10a. State s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, "he "Mod-sal Exarting to use to collect all 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Anne Arundel Maryland Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21076 **USA** 7505 Ackerman Court Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?
1 Xi Yes 2 □ No 1968
If Yes, Give 1072 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: White Specify: þ 3 Widowed 4 Divorced 1972 or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Lab Technician Dentistry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marilyn Totvestad Charles Ayers ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Ayers, Wife 7505 Ackerman Court Hanover, Maryland 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of P
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/22/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor ²² Name and Address of Facility Cremation Society Of Maryland, Inc. <u>299 Frederick Road Baltimore, Maryl</u>and 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GILIOBLASTUMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncriping Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the aftending physician thed for use as the buris Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Mother (Specify) HOS PICE HUIL 1 Inpatient 2 ER/Outpatient 3 DOA : After this of funeral din Medical Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After completely filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manney stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

			State of Maryland / Depa 1- State Amend #2, perMD, g882 8/19/08 TEer Registrar	rtment of Health and r tificate of Death	Mentai Hygie Reg	ene 2008 23437				
	Physici		1. Decedent's Name (First, Middle, Last) Ronald Wright Atwill		2. Date of Death	July 14, 2008 Time of Death				
1	/Medio		4a. Facility Name (If not institution, give street and number) Gilcrest Hospice	4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore				
	Funeral Director		5. Social Security Number 216-42-3526 6. Sex 14D M 2 F 65 Yrs. 7. Age (In yrs. last birthday) 16 Months Days Hours Min. 3. Date of Birth June, Pag Year 1943 9. Birthplace (Str. Country) Mary Mary Mary Min. 3. Days Hours Mi							
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc		10d. Inside City Limits					
	e Mary Ba-f sh	ctor	Maryland Baltimore Lansdown		T	1 ☐ Yes 2 🛣 No				
	th with th	Funeral Director	1019 Regina Dr	10f. Zip Code 21227		g. Citizen of What Country? USA				
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Evantinar must be notified at once.	þ		Nas Decedent of Hispanic Origin? (Sit Yes, specify Cuban, Mexican, Puerting Yes 2 No Specify:	pecify Ye's or No- o Rican, etc.)	14. Race - American Indian, Black, White etc. White Specify:				
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natu he Medical	Completed	(Specify only highest grade completed) (Give life. L	dent's Usual Occupation kind of work done during most of wor. DO NOT use retired) Service	king 16	Sb. Kind of Business/Industry Computer				
land 2	uld be filed Aental Hygi rked other tic event, II	To Be Co	17. Father's Name (First, Middle, Last) Clarence Lee Atwill	18. Mother's Nan Helen	ne (First, Middle, Ma T. Fische	aiden Surname) C				
Mary	nd 2 shoualth and N 27 is man		19a. Informant's Name/Relationship (Type. Print) Victoria Lloyd, step-daughter 2400	g Address (Street and Number or Ru Zion Rd. Lansdo	owne, MD.	City of Toyng - State, Zip Code)				
imore,	Pages 1 a ment of He ant: If item ury or othe		4 Donation 5 Dotner (Specify)	ndel Crematory 0	7-16-08	Oc. Location - City or Town, State Odenton, MD				
Balt	permit. Depart Import any Inj		21. Signature of Euneral Service Licensee 22.	Mbrose Fineral Ho 328 Sulphur Sprii	ome, Inc. ng Rd. A	rbutus, MD. 21227				
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. The not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of	er the mode of dying, such as cardiac	c or respiratory arres	Approximate Interval Between Onset and Death				
	See S	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury)							
68760,	ificate be executed g physician and as the burial-transit	al Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):							
	9 6	Nedical	d							
O. Box	the death certi y the attending ched for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 24 □ Pregnant at time of death 5 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 25c. If yes, outcome of pregnancy 25c. If yes, outcome of pregnancy 25c. If yes, outcome of pregnancy 25c. If yes, outcome of pregnancy 25c. If yes, outcome of pregnancy 25c. If yes, outcome of pregnancy 25c. If yes, outcome of pregnancy 25c. If yes, outcome of pregnancy 25		23d. Date of delivery Month Day Year					
rds, P.	The law requires that the do ate has been signed by the bage 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?				
II Reco	The lar ate has page 2	Completed			24a. Was an autopsy perform 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
Vita	sician certifi irector	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Other	th (Check only one,	nce 6 Sother (Specify) + USDICE				
n of	ng Phy fter this neral d	n: To	27. Manner of Death 1 Matural 5 Pending (Month, Day, Year) Injury		28d. Describe hov	to a Barrer (epacing)				
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (Stre City or Town,	pet and Number or Rural Route Number, State)				
_	e Hospital 124 hours a e Funeral I	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	E, and due to the caurred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)				
	To the I within 2 To the I complete	Me	29b. Signature and title of certifier M. Harthy Ruly, und	29c. License number D 2 5 2 0 5	29 7	d. Date signed (Month, Day, Year)				
	10+1		30. Name and address of person who completed cause of death (Item 23a) (Type, I) A. R. Ley G. Bm (670) N	Y. Charles St.	Balto.	d. Date signed (Month, Day, Year) Uly 14, 2008 Md Zizox				
	Sta Registr		31. Date filed (Month, Day, Year) 22. Registrar's Signature	W						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20, 2008 **Physician** Dorsey William Brandenburg July 8:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 333 Cooley Mill Road Havre de Grace 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 X M 2 □ F 80 Yrs. 220-12-9415 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov 1 ☐ Yes 2 No Harford Havre de Grace Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or ury or other traumatic event, Item Medical Examiliest must be a 21078 USA 333 Cooley Mill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 \sum No 1944 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White ò 3 XWidowed 4 □ Divorced 1945 Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Businessman Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Shock Brandenburg ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 Fineburg Road North East, Maryland 21901 Dorsey J. Brandenburg, Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/21/08 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Ligensee
Thomas Gregor ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mus disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 XNo 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A investigation filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Registrar

29b. Signature and title of certifies

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

GALVEZ

5- UNION

29d. Date signed (Month, Day, Year)

AVE

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O Honth 1755 PM **Physician** Berg Josephine Tine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale Batimora HOSPIta If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 5 1921 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 M 2X F 87 Maryland 215-15-5191 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Show 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "recital Examinat rust be notified at 1 XYes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4216 Springwood Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify þ Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: if Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Secretary Refrigeration 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francisco Capone 2 Tine Antonette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health as Important: If Item 27 is any injury or other trau once. 4300 Springwood Avenue, Baltimore, MD Gregory Berg - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Metro Crematory, Inc. 7/21/2008 Baltimore, MD 21. Signature of Funeral Service Licensee Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD HU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnoumonia-Health care associated **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a co seque e of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed alnutrition Due to (or as a consequence of) Box 68760, Completed by Physician/Medical attending ph . nse IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Dav Year and by the a 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown signed by d 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **☑** No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this After this funeral of 27. May er of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title RES 000 07/20/2008 who completed cause of death (Item 23a) (Type, Print) Franklin Square Dr. Bahimore, MD 900 М. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 300g 1. Decedent's Name (First, Middle, Last) - AM JULY WYNN BARWICK **Physician** ROSEMARY 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CARROLL WESTMINSTER HOUSE DONE HUSAICE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex SECENBUR DG, 1934 WASHIN Hours Days 1 □ M 2 1 F 214-30-0886 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No MANCHESTER Director MM CARROLL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21107 USA YORK Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Black, White, etc. 11. Marital Status Specify: WHITE 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: q 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Homema Ker College (1-4or 5+) Elementary/Secondary (0-12) HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ELINO? LOUISS LIFTON SAMMIE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) YORK STREET MANCHESTER KARLY STONESIFYST 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition HANDUR MARYLAND MATORY LIFTS DELISTRY JULY 32, DOE 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22 CONNELLEY BR. STE A HANDULR ND 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) ecult Physician Due to (or as a c nsequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical 23 Completed by 25 Be Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🍣 cate has been signed by the attending physiclan and page 2 should be detached for use as the burial-transitions. certificate has After this certific funeral director, this within 24 hours after death.

To the Funeral Director: #
completely filled in by the fi

Funeral

Director

28a-f show

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Examiner must be notified at

of Health and Nitem 27 is ma

Baltimore, Maryland 21215-0036

ny, leading to immediate use. Enter Underlying use (Disease or injury t initiated events ulting in death) Last	c. Due to (or as a consequence of): Due to (or as a consequence of):	Aneny		
FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		3d. Date of delivery Month Day Year
t II. Other significant conditions	contributing to death but not resulting in the u	nderlying cause given in Part I.		se contribute to the cause of death?
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
		26. Place of Death		
. Was case referred to medical examiner?		Other:		6 Other (Specify) Hospice
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			
. Manner of Death	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injur	
2 Accident		· · · · · · · · · · · · · · · · · · ·	oof Location (Street an	nd Number or Rural Route Number,

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Malcalus Drive, West minister, MD 21157

aman Date filed (Month, Day, Year)

6 ☐ Could not be

3 Suicide 4 Homicide

32 Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23441 Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July July **Physician** 14, 2008 8:10 P M Roger Beatty /Medical 4a. Facility Name (If not institution, give street and number) 2140 Whistler Ave. 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltimore City 8. Date of Birth 5/Month, Day, 9. Birthplace (State or Foreign MD • If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours NZÍM 2□F 64 215-40-6886 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City. Town or Location 10b. County 28a-f show "natural", or Items 23a or 28a-f shov dical Exa⊡lner πust be notified at MD. 1 Yes 2 No Baltimore City Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 2140 Whistler 21230 **USA** Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatte event." 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 25 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No White Specify. Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) Machine Machine Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell Beatty Garnette Shepard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2140 Whistler Ave., Baltimore MD., 21230 Carol A. Beatty/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Semation 3 Removal from State Odenton, Maryland West Arundel Cematory 7/17/2008 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Ambrose Funeral Home, Inc. Hati 2719 Hammonds Ferry RD. Lansdowne MD. 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the dath shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final (general Physician real disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and sthe burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

page 2 certificate director. Be P this funeral Medical Certification: After filled in by the fu

or Attending Physician;

death.

within 24 hours a

To the Funeral I

completely filled To the Hospital

autopsy performe

28d. Describe how injury occurred

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural
Accident 5 Pending investigation

3 ☐ Suicide

4 ☐ Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 No

29a, Certifier

6 Could not be

determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. Handrer Street, Bathimone

31. Date filed (Month, Day, Year)

Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23442 For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ye ar Laura 20 2008 Boyer July 4:20A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Morningside Assisted Living Hanover Anne Arundel If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🔀 F Months Hours Min Yrs 90 215-32-4460 Aug. 10, 1917 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Anne Arundel Hanover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21076 U.S.A. 7548 Old Telegraph Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Specify: White 1 ☐Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ivan Boyer Elva Clark 19a. Informant's Name/Relationship (Type. Print) Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Boundary Lane Saint Michaels, MD 21663 Mrs. Joyce Boyer-Williams/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Duo to (or as a prinsequence of): n Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 100 1 Yes 2/1 No

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

and

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Ifem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Mydies in Inst be rother traumatic event, If a Mydies is any Injury or other traumatic event, If a Mydies is

Maryland 21215-0036

Baltimore,

Box 68760,

Division of Vital Records, P.O.

Exami burialphysician s the burial Physician/Medical attending p for use as t signed by the a þ Completed r this certificate has ral director, page 2 s Be Certification: To After thi To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

IF FEMALE: 23b. Was decedent pregnant 9 🗆 Unknown

								1 103 =	
25. Was case referred to medical examiner?					26.	Place of Death	n (Che	eck only one)	
1 Yes 2 1 1 No	Hospital:	I ☐ Inpatient 2 [☐ ER/Outpatient	3 🗆 [OOA Other: 4	I ☐ Nursing Ho	me :	5 Residence	6 Domer (Specify,
27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident investigation	(1	ate of Injury Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work?			Describe how inju	

3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

(Check only					irred at the time, date and place, and due to t ation, in my opinion, death occurred at the tin	
one)				anner s		
9b. Signature and	title of certifier	V	7	/	29c. License number	29d. Date signed (Month, Day, Year)

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

				12	200			_1	<u>' </u>	100	
30. Name and address of perso	n who completed caus Gorbaly	se of death (Item:	23a) (Type, Prin	a disa	Port	(Drive,	Glen	Burnie	and.	,2106
31. Date filed (Month, Day, Yea	r) 37. F	Registrar's ⁽ Signatu	re 🦽						7	- /	

State Registrar

Medical

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 6:00 P.M ROBERT CARVILLE BEVANS, SR. 18, JULY 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GILCHRIST CENTER BALTIMORE TTMONTUM er 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) If Unde 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2□ F Yrs 219-05-6382 12/5/1916 MARYLAND Director 91 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show nd Mental Hygiene. marked other than "natural", or items 23a or 28a-1 shov imatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🛛 No Director MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA Funeral 1930 EDGEWOOD ROAD 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐Yes 27 No Specify Specify: WHITE Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) YEARS Elementary/Secondary (0-12) DESIGNER COMMERCIAL KITCHEN 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 1 nent of Health and Mental CHRISTIANA SCHLISSLER ٩ SAMUEL O. BEVANS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health BORGHILD BEVANS/WIFE 1930 EDGEWOOD ROAD PARKVILLE, MD 21234 more. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ö 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) METRO CREMATORY, INC.: 7/21/2008 CATONSVILLE, MD Balti 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. - rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on jach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) miler **Physician** /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burfal-trans Due to (or as a consequence of) physician the burlal Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) o. 9 Unknown 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 WNo 2 🗆 No 1 ☐ Yes 1 □Yes Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To this of 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division To the Hospital or Attending 5 Pending investigation 2 🗌 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAron HAMURS W 31. Date filed (Month, Day, Year) State 22 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 2 1ª, 12:35P w **Physician** 2008 Mary Cecilia Brown /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Care Center 8. Date of Birth NOV8, 1918 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral 1 □ M X X Hours Min. Months Days MafÿTand 89 212-10-5354 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examinar must be restitled at once. 1√2Yes 2 No Director Baltimore City Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21224 361 Gusryan Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ď No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: ⋛ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home (unk) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sabrina John Blusiewicz ပ 19a. Informant's Name/Relationship (Type. PrinDaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Katherine W. Mansberger 152 Holly Circle Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7-24-2008 Baltimore, Maryland Holy Rosary Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilite Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licens Wh 21222 1201 Dunda1k Avenue Baltimore, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician enra bron rende 10 /Medical Due to (or as a consequence of): Examiner 10 Sequentially list conditions Due to for as a gonse sience of Examiner day, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy rmed2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 🖪 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.O. Box 68760, Division of Vital Records,

altimore, Maryland 21215-0036

law requires that the death certificate be executed physician at the burial attending pl signed by the a cate has been się page 2 should b e Hospital or Attending Physician: The 24 hours after death.
9 Funeral Director: After this certificate h funeral director, the filled in by completely To the I within 2

and burial-tran

State Registrar

DHMH 17 Rev 1/2001

Ke Year 31. Date filed (Month, Day,

29b. Signature and title of certifie

(Check only one)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

July 21, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cloudes St. Balto md 2,20k Bmo 6701 N.

2008

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05542 2008 23445 State of Maryland / Department of Health and Mental Hygiene Gary Andre Cooper, Jr. Certificate of Death 1- For State Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 20, 2008 0400 hrs Andre soper Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) NIA **Baltimore** University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (in yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Foreign 10-02-1978 Country) Director 212-94-730 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Ves 2 No s 23a or 28a-f show : Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral White, etc. Armed Forces? Married Never Married 2 2 No Yes Yes 2 No specify: Specify. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If Yes, Give Year Divorced 3 Widowed ≥ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed on vergenia College (1-4 or 5+) Elementary/Secondary (0-12) it: If item 27 is marked other than other traumatic event, the Medical ventory 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last 12a -15a Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Nama elationship (Type, Print) aton Ave. Baeto, md. NO. 2122 Banks 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Cremation 3 Removal from State 2 1 Burial -08 Arbutus mem Donation 5 Other Specify: 0 22. Name and Address of Facility 70 FredHILTON of Funeral Se vice Licer rch F.H. a ma complications that caused the death. Do not enter the model of dying, such as cardiac or respiratory arrest, shock, or heart he disease, or Between Onset and Physician fai ur . List only one cause on each line Death /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease or condition resulting in death) aminer Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial - trans Physician/Medical AMENDED UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth attending | for use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown þ Completed 24b. Were autopsy findings available 24a. Was an has been s prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes rector, page 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be Other Hospital: Residence 6 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA No this 1 V Yes 28a. Date of Injury (Month. Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Subject shot Certification: Jul (20, 2008) 0313 hrs Yes 2 V No Natural Pending Director: 24 hours after death. 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 206 North Hilton Street, Baltimore, MD Could not be 3 Suicide determined (Specify) Sidewalk To the Funeral 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

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Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

headore

30. Name and address of person

31. Date filed (Month, Day, Year)

Theodore M. King, Jr., MD.

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

July 20, 2008

and manner stated

who completed suse of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Tandreka Iesha Childs /Medical Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A If Under 24 Hr Birthplace (State or Foreign Country) . Age (In vrs. last birthday) **Funeral** Year) Hours Months 1 □ M 2 □ F 28 Yrs. 23 6 MD Director 214-96-1108 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 □ No MD N/A Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 "natural", or items 23a 1431 N. Carey St. Apt. 203 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ∐Yes 2KNo If Yes, Give Year or Dates: Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) John Hopkin Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Aramark/University Food Service 12th lyr. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Childs George Valerie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 116 N. Paca St. Apt. 312 Baltimore, MD 21201 Valerie Burton-mother or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Pk; 7/23/2008 Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. MD 21202 1101 E. North Avenue Baltimore, Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of) Examiner sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. ed by the detached i 9 Unknown 9 Unknown signed by the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 4 Unknown 2 No 3 Probably 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? perform 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manual of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and He of certifier maryland General Hospital who completed cause of death (Item 23a) (Type, Print) Hagras 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

08-05462 Glen Ellis Curtis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

en Ellis Curtis		State of Maryland / Departm 1- For State Certific	nent of Health and Mental Hy cate of Death	rygierie 2	2008 2344				
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Yea	3. Time of Death 1029 hrs				
edical Exami ৺ ५,	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	July 16, 2008 4c. County					
		2310 Tarleton Lane Apt. F	Parkville						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi		For					
Director		220-86-6297 1XM 2F 40	Yrs.	4 15 1968	Country) MD				
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location	10d. Inside City Lin					
and f show	ь	MD Baltimore P	arkville		1 Yes 2 X XNo				
Mary r 28a-	Director	10e. Street and Number 2310 Tarleton Lane Apt. F	10f. Zip Code 21234	10g. Citizen of W	hat Country?				
death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No- 14. Race	e - American Indian, Black,				
death or item must b	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2XX No	If Yes, specify Cuban, Mexican, Puerto		e, etc.				
s after iral", niner	ò	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a	Yes 2XX No specify: Decedent's Usual Occupation (Give kind of vectors)	Specify:	Black usiness/Industry				
72 hou n "nati	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti	Nort Nort	hwood Ridge				
0036 within iene.	Completed	12th N/A	maintance		tments				
215-(e filed al Hyg eed oth	Be C	17. Father's Name (First, Middle, Last) Glenn E. Duncan		18.Mother's Name (First, Middle, Maiden Surname) Christine A. Cur					
212 nould b id Men is marl	To E		9b. Mailing Address (Street and Number or I	Rural Route Number, City or Tov	wn, State, Zip Code Apt 2				
, MC and 2 st ealth an em 27		020:00	2202 Brookfield A		- City or Town, State				
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Ex miner must be notified at once.		1XXBurial 2 Cremation 3 Removal from State Range	atory or other place) 'yland Nat'l Mem.7	/22/08 Laur	el MD				
altin mit. Pa partmei portan		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	LOO Name and Address of Espilits	ARCH FUNERAL	HOME-EAST				
	N V	23a. Part I. Enter the disease, or complications that caused the death. Do	11101 E. North A	venue Baltim	ore, MD 21104				
Physician Medical		failure. List only one cause on each line.	ation & cocaine use	or respiratory arrest, shoot, or ne	Between Onset and Death				
xaminer		Immediate Cause (Final disease or condition resulting in death) a. NATCOLIC INTOXIC Due to (or as a consequence of):	ation & cocaine use						
	Ŀ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):							
	min	cause. Enter Underlying Cause (Disease or Injury that initiated			34				
cuted nd transit	Medical Examiner	d d		A A					
be exertion a sician a surial -	dica			perME, g882 8/7/08 TT 2 8/15/08 TT					
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - transit	ın/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnance 1 Live birth	cy 2 Fetal death 3 Ectopic pregn	23d. Date of Month	of delivery Day Year				
Box 687 death certificate attending ped for use as the	Physician/	past 12 months? 4 Pregnant at time of death 1 Yes 2 No 9 Unknown g Unknown	5 Other (Specify)		1				
O. B it the de lby the			ting in the underlying cause given in Part I.	23e. Did tobacco use con	tribute to the cause of death?				
of Vital Records, P.O. ng Physician: The law requires that the thin certificate has been signed by meral director, page 2 should be detach	ed by				Probably 4 V Unknown				
ords aw requas been 2 shoul	Completed			24a. Was an 24b. autopsy performed?	. Were autopsy findings available prior to completion of cause of death?				
Rec The l ficate l	Con		26.Place of Death (Check	1 Yes 2 No	1 Yes 2 No				
/ital ysician iis cert	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: Inpatient 2 ER	ious	ing Home 5 X Residence 6	✓ Other: Seene				
fing Ph	n: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28t	b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occu	irred				
Division tal or Attendi rs after death al Director: /	catic	2 Accident Investigation 7/16/08 Fnd u	nk 1 Yes 2 X No	unk 28f Location (Street and Num	ber or Rural Route Number, City				
Divi ital or ral Dir	Certification:	3 Suicide 6 X Could not be determined (Specify) Home	, talli, ollood, lastary, allias ballang, etc.	or Town, State)	Ln. Parkville.				
Divisior To the Hospinal or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, of	death occurred at the time, date and place, an	d due to the cause(s) and mann	er as stated.				
To the within To the comple	Medical	2 Medical Examiner: On the basis of examination and/one and manner stated. 29b. Signature and title of certifier	29c. License number		gned (Month, Day, Year)				
		(V G. Culo, MAD)	O.C.M.E.	July 17, 2					
		30. Name and address of person who completed cause of death (Item 23a							
		22 Posintrado Cignostas	11 Penn Street, Baltimore, MD 21	201					
S Regis	tate trar	1111 0 9 2008 Marie # 40	March 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008	23448
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andiony vv. ood		1- For State Certificate of Death Registrar		2000 2344 Reg. No.				
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Mont <mark>il 6</mark> July 15, 2					
V≃ "cal Exami:	ner		July 15, 2 or Location of Death	4c. County of Death				
			Baltimore					
Funeral Director		1xxM 2 F 46 49 Yrs.	ear If Under 24Hrs. 8. Date of B ays Hours Min. Dec. 6	irth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD				
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits					
*	٦	MD Baltimor	re e	1 XX Yes 2 No				
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?				
ith the 23a or notifie			21217 Hispanic Origin? (Specify Yes or N	o- 14. Race - American Indian, Black,				
leath w	Funeral	1 XXNever Married 2 Married 1 Yes 2 No	pan, Mexican, Puerto Rican, etc.)	White, etc.				
after crall, or	by F	Widowed 4 Divorced if Yes, Give Yeer 1 Yes 2 XX		Specify: Black				
2 hours afte "natural", Examiner			pation (Give kind of work done ife. DO NOT use retired)	16b. Kind of Business/Industry				
5-0036 led within 72 Hygiene. other than '	Completed	12 server		restaurant				
15-0 filed w Hygie d othe			18.Mother's Name (First, Middle,	·				
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical	o Be	19b Mailing Address (St	Anita (JOACES umber, City or Town, State, Zip Code)				
and and	-	Anita Coates / Mother 1640 N. Apple	ton Street; Baltimon					
nore, Mages 1 and 2 and 6 Health tt: If item 2 other traun		20a. Method of Disposition 20b. Place of Disposition (Name of State Surial 2 Cremation 3 Removal from State crematory or other place)	cemetery, Date	20c. Location - City or Town, State				
Baltimore, permit. Pages lar Department of Hee Important: If ite		4 Donation 5 Other Specify: Mount Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Addr	07/22/2008 ess of Facility Wylie Fune	Baltimore, Maryland				
Bal permi Depar Impo injur			mor Street; Báltimor					
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyi failure. List only one cause on each line.	ng, such as cardiac or respiratory a	rrest, shock, or heart Approximate Interval Between Onset and				
'Medical xaminer		Immediate Cause (Final disease a Gunshot wound of torso		Death				
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,						
	iner							
d b	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
executed in and il - transit			8 TT					
'60, sate be exe physician a	Medical	UNPENDED WAMENDED #8 per FH G881 7/25/0 #2 7 per/F&fh 2881 7/29/08 IF FEMALE: 23c. If yes, outcome of pregnancy	.WS	23d. Date of delivery				
Sox 687 leath certific e attending p	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 Ectopic pregnancy	Month Day Year				
Box 687 e death certific the attending ped for use as the	Physic	1 Yes 2 No 9 Unknown Greath 5 Other (Specify)						
P.O. es that the gened by the detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause		tobacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown				
ords, P w requires t s been sign should be o	ted		' ' ' 24a. Wa					
COF	Completed		per	opsy prior to completion of cause of death?				
tal Rection: The			ace of Death (Check only one)	2 No 1 Yes 2 No				
Vita hysicia this ce	To Be	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA	Other Nursing Home 5	Residence 6 Other:				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi		. 27. Manner of Death Zoa. Date of injury Zob. Time of injury Zoc.	Injury at Work? Yes 2 No 28d. Describ Subject sh	e how injury occurred lot				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse	or Town	(Street and Number or Rural Route Number, City State) ood Avenue, Baltimore, MD				
To the Hos within 24 h To the Fun completely	Medical (e, date and place, and due to the ca nion, death occurred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)				
	ž		ense number	29d. Date signed (Month, Day, Year) July 16, 2008				
		100 (e e e e e e e e e e e e e e e e e e	C.M.E.	3019 10, 2000				
<u>5</u>			et, Baltimore, MD 21201					
St Regist	trar							
DHMH 17 Rev 1/2	001	1 OCME ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July **Physician** 2008 9:00 A M Josef F. Dupac /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1154 Pelham Wood Road Parkville Baltimore 8. Date of Birth (Month, Day, Oct 9, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Days 1 X M 2 □ F 1924 Czech Republic 215-60-1546 83 Director Usual Residence of Decedent death with the Maryland 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show if than "natural", or items 23a or 28a-f show the Medical Examinations to notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 21234 USA 1154 Pelham Wood Road by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐ Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 □ Yes 2 🗓 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'a yi njury or other traumatic event, the Medical Approximation of the Medica College (1-4or 5+) Elementary/Secondary (0-12) Laboratory Technician Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Marie Cisarova ပ Bedrich Dupac 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1154 Pelham Wood Road Parkville, Maryland 21234 Ludmila Dupac, Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 07/19/08 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. Signature of Funeral Service Ligensee ²² Cremation Society Of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician elanomo mon /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached f □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 ☐ No 3 ☐ Probably 4 Munknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

) Sta

State 31. Date filed Registrar

30. Name and address of

fonth, Day, Year)

3. Registrar's Signature

d cay e of death (Item 23a) (Type, Prin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Day 2008 Year Millie DeSisco 17 6:40 A M 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson 1410 Shefford Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Hours Days Min Months 1 □ M 2 1 F Pennsylvania November 20,1915 92 170-07-0868 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo Dundalk Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 2465 Fairway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) School Cafeteria Worker 7 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Colantonio Contino Parenti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21239 1410 Stefford Road, Towson, Maryland Donna Holland Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 21, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland Sacred Heart Of Jesus Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Surfaure of Fone al Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease of complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Disease Immediate Cause (Final disease or condition resulting in death) END STAGE HEART Due to (or as a consequence of): Sequentially list conditions, if any, leading to influentate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Year Month Day Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 🗌 Yes 2/2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Daugnter's Hone Other: 4 Nursing Home 5 Residence 6X Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d Describe how injury occurred Injury 1 Natural 5 Pending investigation М 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Physician /Medical Examiner Box 68760, P.0. Records, of Vital Division

burial-trai attending physician for use as the buria that the death certificate be signed by the a page 2 should peen certificate has Physician: director, this To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dil

Physician

Examiner

Funeral

Director

the Maryland

s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be neithed as

permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other i

and

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

nu

DRAKE

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** EDMONDS 16 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE HARBOR HOSPZTAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 😿 F 19-32-252 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show ed other than "natural", or items 23a or 28a-f show event, The Medical Evanture, rust by multiple at 1 Yes 2 □ No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number HILL 122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 ⊅No If Yes, Give Year or Dates: Specify: β 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Lontolic TOUSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file tment of Health and Mental H tant; If item 27 is marked oth Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a_Informant's Name/Relationship (Type. Print) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) permit. Pages Department of Important: If it any Injury or o 1 Rurial 2 Cremation 3 Removal from State OWINGS MILLS NO 4 □ Donation 5 □ Other (Specify) 21. Signature uneral Service Licen md. 21229 23a. Part . Er a the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r neart failure. List only one cause on each line. Immediat use (Final disease of condition resulting in death) SEPTIC 3 DAYS **Physician** /Medical ACZDOSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FAZLURE Examir the burial-transi Due to (or as a consequence of) Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 more 1 ☐ Yes 2 No Month Year 5 Other (specify) signed by the a Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò HNEM 2A 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed HYPERTENS 20N 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 ₩No 2 🖳 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ♠ No • Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director; filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct

completely filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

JULY, 16, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUTTARTHIL,

RESOOO HANOVER ST, BALTZMORE, ND, 21215

3001 30U74

32. Registrar's Signature

08-05482 Bryant Elliott, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of	Maryland /	Department	of Healt	h and Me	ental Hygiene

2008 23452

		1- For State Registrar		Ce	ertificate d	of D	eath			R	eg. No.	00	0 2	- 040
Physicia Medical Exami			lliott Jr							Date of Dea Month July 17, 2	th Day Yea		3. Time of I 0913 h	
r.		4a. Facility Name (if not institution 1701 William Street	on, give street and no	umber)			City, Town, or Lo	ocation of	Death		4c. County of	of Death	Α	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		lf Under 1 Year	If Under		8. Date of Bir	th(MM/DD/YYYY	9. Birth	place (Stat	te or
Director		217-84-5813		Min.	05/	13/1971	Foreign Cou		MD					
any.	·	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					1			10d, Inside	City Limits			
*	tor		erset					Mari	on					2 No
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Director	10e. Street and Number 5365 Bivens F	Road			: 10	0f. Zip Code	21838		10g. Citizen of What Co.			try?	
C S th with the sems 23 at be no	Funeral	11. Marital Status 1 Never Married 2 X Market		cedent Ever in U			ecedent of Hispa specify Cuban, M				- 14. Race White	- Americ	an Indian, E	Black,
after dea	by Fur		1 Yes	2 x No			es 2 x No		donto ra	ouri, oto.)	Specify:		hite	
hours a	ed b	15. Decedent's Education (Special	cify only highest grad		16a. Decede	ent's l	Jsual Decupation of working life. D	n (Give kir			16b. Kind of Bu			
71215-0036 Id be filed within 72 hours after Mental Hygiene. narked other than "matural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1	1-4 or 5+)			onstruct			-,	Resid	enti	al	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Bryant K.	,	ott Si			18	.Mother's			Maiden Surname) McBride	,		
D 21215 should be file and Mental H 7 is marked on natic event, th		19a. Informant's Name/Relations	hip (Type, Print)			ng Ad	Idress (Street a				nber, City or Town	n, State,	Zip Code)	
MC 2 s alth au m 27 aum a	-	Heather Elliot 20a. Method of Disposition	t (sr	ouse)			Bivens R							
imore, MD 2		1 X Burial 2 Cremation		om State	crematory or c	other p		- Î.	July		20c. Location -	•		
Baltimore, pemit. Pages I at Department of He Important. If ite injury or other tr	+	4 Donation 5 Other Sp 21. Signatur, of Funeral Service		ME			e Cemete		_	008	Elkride			
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Physician /Medical	a I	23a. Part I. Enter the disease, or failure. List only one cause	on ach line.							espiratory arro	est, shock, or hea	irt	Between	ate Interval Onset and
xaminer		Immediate Cause (Final \sease or condition resulting in death)		n intox consequence of	<u>icatior</u>	1 8	cocain	e us	e .			$\overline{}$	De	eath
	اة	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	nf)·							_	<u> </u>	
	티	(Disease or injury that initiated events resulting in death) Last	c	consequence										
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760, cate be ext physician the burial.	n/Medical	X UNPENDED	X AMENDED	23a,2/ 23a,p	,28a-f, er ME g	388 388	erME, g8 2 8/13/	881 7 08 T	//28/ L	/08 T T				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi		F FEMALE: 3b. Was decedent pregnant in the past 12 months?	e 1 Live b	outcome of preg irth	2 F	etal d	eath 3	Ectopic p	regnanc	y	23d. Date of Month	delivery Da	ау	Year
Box 687 e death certific the attending of for use as the	Physicial	1 Yes 2 No 9 Unk	nown g Unkno	ant at time of de wn	eath 5 0	ther	(Specify)				Î			
P.O. Bo	<u>a</u>	Part II. Other significant condition	ons contributing to	death but not r	esulting in the	under	rlying cause give	en in Part	l.		bacco use contrib			
ds, P.C										1 Yes	2 No 3			
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should be	Completed								_	autop	sy pi		ppsy finding mpletion of	
	O	25. Was case referred to medical	9			_	26.Place of	Death (Cl	heck onl	1 Yes :	2 No 1	✓ Yes	2	No
Nysici	0	examiner? 1 ✓ Yes 2 No		npatient 2	ER/Outpatien			her ₄ N	lursing H	lome 5	Residence 6	Other: \$	Scene	
- # ^4		7. Manner of Death 1 Natural 5 Pendi	28a. Date (Month,		28b. Time of					id. Describe h I nk	low injury occurre	id		
Division tall or Attendians after death. all Director: A led in by the fu	9	2 Accident Invest	tigation		ome, farm, stre	et, fa	ctory, office build				treet and Number	r or Rura	Route Nu	mber, City
		4 Homicide determ	mined (Specify)		in dwe				j. D	altimo	re, MD			t
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director: Completely filled in by the	0 (Check only 1 Certifying Physical Example Check only 2 Medical Example Check only	ysician: To the best niner: On the basis o and manner st	f examination a	ge, death occu nd/or Investiga	rred a ition, i	at the time, date a in my opinion, de	and place eath occur	, and du red at th	e to the cause e time, date a	e(s) and manner and du	as stated ue to the	cause(s)	
F \$ F 8	2	9b. Signature and title of certifier		ateu.			29c. License ni	umber	-		29d. Date signe	d (Monti	h, Day,Year	7)
							O.C.M.	E. —			July 18, 200)8		
OCME	3	 Name and address of person v Mary G. Ripple MD. 	who completed cause Deputy Chief M			1 Pe	enn Street, B	altimore	e, MD	21201				
Star Registra		1. Date filed (Month, Day, Year)	32. Reg	gistrar's Signatu	re									
Drivin 17 Rev 1/200				- A	ORIGINA	Í		-						
OCME 2006					VIII/	_								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend item 12 per fh 881 7-22-08 vt. State of Maryland? Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marvin Ellis Eddy July 20 2008 8:25 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Carroll Hospital Center Carroll Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Form (Month, Day, year)
April 21, 1947 Maryland 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 XM 2□ F Days Hours Min 61 |216-44-7296 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f sh 1 ☐ Yes 2 ☑ No Director Westminster Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o 1142 Humbert Schoolhouse Rd. 21158 U.S.A. "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1966-72 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Give 72 1 ☐ Yes 2 XNo Specify. Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Vehicle Mechanic Federal Express If item 27 Is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marvin Roy Eddy Inez Marie Hupp ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 I 1142 Humbert Schoolhouse Rd. Westminster, Sandra Eddy - wife Date 24, 2008 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) July 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Maryland Veterans Cem. Owings Mills, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A . Hente Elland 3296 Charmil Dr. Manchester, MD. 21102 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of) Examiner 19 bete icais Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No for Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown þ cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient မှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō To the Hospital within 24 hours a To the Funeral L 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21074 / Sayan Fratali MD

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL 2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23454 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day ENGELMAN 7:37 AM 2008 07 20 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HOPKINS N/A BAYVIEW Social Security Number If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2**X**F Months Days Min. Hours 206-16-3612 82 PENNSYLVANIA 11/9/1925 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits LYCOMING DUBOISTOWN 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2581 RIVERSIDE DRIVE 17702 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify If Yes, Give Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KENNETH GILTNER HELEN SHAFFER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA WEIN/DAUGHTER 2651 RIVERSIDE DR. DUBOISTOWN, PA 17702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WILDWOOD CREMATORY 7/23/2008 WILLIAMSPORT, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD.

RES OOD

BALTIHORE, MD

AVENUE

TOWSON, MD

permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur

Physician

/Medical

JOHNS

10a. State

PA

Examiner

Funeral

Director

28a-f shov

Director

Funeral

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Completed

Be

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experient must be notified at

and Mental

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

law requires that the death certificate be executed

To the Hospital or Attending Physician: The

within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

Division of Vital Records, P.O. Box 68760

Examine physician and s the burial-trans Physician/Medical Medical Certification: To Be Completed by page 2 s : After this certification funeral director, p

23a. Part 1. Enter the disease, or corr shock, or heart failure. List only	plications that caused the death. Do not enter one cause on each line.	the mode of dying, such as cardiac	or respiratory arrest,		l Between
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS			Onset 2	and Death
Sequentially list conditions,	Due to (or as a consequence of): b. LEFT HIP I Due to (or as a consequence of):	NFECTION		·0N	IE MO
Cause (Disease or injury that initiated events resulting in death) Last	C				
IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 🎝 No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day	Year
Part II. Other significant conditions	contributing to death but not resulting in the und	erlying cause given in Part I.		o use contribute to the cause 2 □ No 3 □ Probably	of death?
			24a. Was an autopsy performed?		of cause of
25. Was case referred to medical examiner?	Harried A.		th (Check only one)		
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 Residence	6 ☐ Other (Specify)	
27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	- I	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		t, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route ate)	Number,
29a. Certifier 1	ysiclan: To the best of my knowledge, death on niner: On the basis of examination and/or inveand manner stated.	occurred at the time, date and place stigation, in my opinion, death occu	e, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cau	ise(s)
29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month, Day, Yea	ar)

State

Registrar

EASTERN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

4940

SILVA

31. Date filed (Month, Day, Year)

			for State Registrar	State of N	/larylar	-	artmen rtificate			and M	-	_				
	Physici /Medi		1. Decedent's Name (First, Middle,	Last) a Verniece	Floci		moun				2. Date of De Month July	ath Day	2008	8	3. Time (A M
	Examir		4a. Facility Name (If not institution,	give street and numbe	r)		4b. City,	Town, or	Location o	f Death		4c.	County of D	eath		
-	18		Howard County G				1	blum		0411			Howai			
<u>St</u>	Funeral Director		5. Social Security Number 500 16 8969 Usual Residence of Decedent	3. Sex 1 □ M 2 🕱 F	86	. last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da May 3,	y, Year)		Countr	ce (State y) souri	or Foreign
	/land ow at		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							100	d. Inside (City Limits
	Many a-f sh ified	햦	MD Howard	-	Je	essup									1 ∐Ye	s 2 XNo
	or 28	Director	10e. Street and Number	-			10f. Zip	Code				10g. Citiz	en of What	Countr	y?	
	ath w	ra	7928 Savage Gui	lford Rd			207						ited S			
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2□ Marrie 3 ▼Widowed 4 □ Divorced	12. Was Deceder Armed Forces d 1 1 2 Yes 2 [If Yes, Give Year or Dates	s?] No	'	Was Deced If Yes, spec 1 ☐ Yes 2	iry Cubai	spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		4. Race - Al Black, W Specify:		c.	
Maryland 21215-0036	n 72 hou "natura ledical E	Completed I	15. Decedent's (Specify only highest	Education		(Give	dent's Usua kind of wor DO NOT us	k done d	urina most	of worki	ing	16b. Kir	d of Busine			
7	withii iene. r than the M	dmo	Elementary/Secondary (0-12)	College (1-4o	r 5+)		altor	e remed)				Re	al Est	ate	4	
פַ	al Hyg other	Be C	17. Father's Name (First, Middle, La				<u></u>		18. Mothe	r's Name	(First, Middle,			<u> </u>	<u> </u>	•
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Jar			19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	Al Route Numb	er, City or	Town, State	e, Zip C	ode)	
	it of Health If item 27 i		Maureen W. Lynck 20a. Method of Disposition	n/Daughter	206 1	7928 Place of Dispo			ulfo		d Jessu				-	
<u>5</u>	0 0		1 ☐ Bunal 2 【Cremation 3		е	cemetery, crer	natorý or ot	her place					cation - City		ı, State	
altimore,	permit. Pag Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li			rdent C					-2008		over,			
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gell.	Physician /Medical Examiner	- Pa	23a. Part1. Enter the disease, or cand shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	a. Septic Due to (or a b. Pneumo	line. Shoots a consequence onia	ck juence of):	er the mode	e of dying	, such as	cardiac o	or respiratory a	rest,		l li	approxima nterval Be Onset and	etween
58/60,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner														
C. Box	that the death certific led by the attending p detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑XNo 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown							23			23d. Date of delivery Month Day Year			
Records, P	luires tha	by	Part II. Other significant condition	s contributing to death	but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to		e contribute			
S	w requ	lete									24a. Was					
		Completed	25. Was case referred to medical								autor perfo 1∐ Yes	rmed? 2₩ No	24b. Were prior t death 1 \square Y	ocomp ?	letion of o	cause of
	Physician: r this certific ral director,	To Be	examiner? 1 Yes 2 No	Hospital:	tient 2 🗆	ER/Outpatien	1 3 DO	Othor	,,		(Check only o		Пон <i>(</i> а	15.1		
			27. Manner of Death	28a. Date of In	jury	28b. Time of		3c. Injury Work			ne 5 Resid			pecity)		
<u>ö</u>	Attending r death. ector: Afte by the fune	atio	1 Natural 5 Pending 2 Accident investigat		ay rear	Injury	М		es 2∐N	10						
	F & F C	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of it	njury - At ho etc. <i>(Specif</i>	ome, farm, stre	eet, factory,	office		2	28f. Location (S City or Tox	Street and n, State)	Number or	Rural F	oute Nur	mber,
	To the Hospital of within 24 hours aft To the Funeral D completely filled in	edical	29a. Certifier 1X Certifying (Check only one) 2 Medical Ex	Physician: To the bes caminer: On the basis and manners	of examina	wledge, death	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) a date and	and manner place, and c	as stat	∍d. ne cause((s)
	Veith Cool	Σ	29b. Signature and title of certifier	(29c.	License	number			29d. Date	signed (Mo	nth, Da	y, Year)	
	<		1 pm	. Uh	m		D	0041	.248			Jul	y 19,	200	8	
6)		30. Name and address of person who George I. Okang					.cine	Litt	tle 1	Patuxen	t Pa	rkway	Col	umbi	a MD
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	trar's Signa	ature	A. a. M									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1 1 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 19, 2008 5:00 AM JULY Harold Walter Fairchild, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Medical Towson Baltimore Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1√2 M 2□ F 217 26 0223 92 Dec 10 1915 NY Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State ns 23a or 28a-f show 1 ☐ Yes ♥☐ No Directo MD Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 7 Dodworth Ct. #204 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items Pages 1 and 2 should be filed within 72 hours after 1X∑Yes 2 ☐ If Yes, Give Year or Dates: 2 No altimore, Maryland 21215-0036 1 ☐Yes 27 No Specify: white 2 3 Widowed 4 Divorced Completed th and Mental Hygiene.

7 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Operations Manager MD State 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Fairchild Olive Hawkins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a t: If item 27 is y or other trau Dodworth Ct #204 Timonium MD 21093 Nancy Fairchild/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition State Department of Important: If any Injury or once. 5 ☐ Other (Specify) Meadowridge Memorial Park 7/23/08 Elkridge 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley 21. Signatur Inc Bryan/W Clary Padonia Rd., Timonium 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PANCYTOPENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit stely filled in by the funeral director, page 2 should be detached for use as the burial-transit MYELODYSPLASIO Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by LACTIC ACIDOSIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 08

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** JU Danielle Nicole Feather 2008 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Anne Arundel Baltimore-Washington Medical Center 8. Date of Birth (Month, Day, May 23, 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2\ F Months Days Hours 1983 May Director 213-11-2396 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or Items 23a or 28a-f sho 1 □Yes 2 No Pasadena Director Marvland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21122 177 Southwood Road by Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced White "natural" Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) <u>Dependent</u> Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kincer Feather Kimberly Α. Jamie ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Parents) Department of Health ar Important: If item 27 is any Injury or other trau once. 8 Jamie W. & Kimberly A.Feather 177 Southwood Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem. Pk. 07/21/2008 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) Parkare and Address of Facility and Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran P.O. Box 68760, physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Po Month Year Day 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by certificate has been sign rector, page 2 should be 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 210 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 tripatient 2 ER/Outpatient 3 DOA Certification: To s after deatn. al Director: After th 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 A Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

State Registrar 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Hospital 305 🐲. Registrar's Signature DOD14147

305 Glen Burnie

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July ^{Day} 2008 **Physician** Μ. Giese 12:45 P M 17 Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Mercy Ridge Timonium 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🕽 F June 19,1916 92 Director 107-03-3029 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Maryland Examination must be notified at any injury or other traumatic event, Ite Maryland Examination 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🕅 No **Funeral Director** Maryland | Harford Havre De Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21078 2123 Sherwood Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 📉 No Specify Completed by 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frieda Faddoul ပ္ Joseph Mansour 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Giese Daughter 4 Upland Road, #22 Baltimore, Maryland 21210 Date 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-19-2008 MAryland Hilltop Service Corp: Towson 22. Name and Address of Facility Service Lipe Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one call se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 ears **Physician** 8 aa disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any local to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 No 1 ☐ Yes 2. NO 1 🗌 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 | Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier 1년 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death [Item 23a) (Type, Print)

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32. Registrar's Signature

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	Examin		4a. Facility Name (If not institution, g				r Location of Death		4c. County of Dea	
			Potomac River				nman Point If Under 24 Hrs. 8	Date of Righ	Charles	
	Funeral			.Sex 7.Ao 1%∑M 2□F	ge (In yrs. last birthday) Yrs.	Months Days	Hours Min.	Month, Day, Ye cember 20	ar) G	thplace (State or Foreign ountry)
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	land	r	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
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	72 hours after death with the Maryland natural; or Itame 23e or 28e-f show Ital Examinat must be notified at	Funeral Directo	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Am Black, Whi	
õ	or It	YF	1 Never Married 2 Married	1 ☐ Yes 2X If Yes, Give Year or Dates:] No	X Yes 2□ No	Specify:	1 1	Specify:	
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<u>a</u>	id be ental ked ic ev	To Be	Jose Cipriano	Guardado			Marinade	e Jesus V	/a11e	
ar y	s 1 and 2 should be filed within 72 hours after death with the Marylan if Healith and Mental Hygiene. If Healith and Mental Hygiene "natural", or Itame 23e or 28e-f show them 21 is marked other then "natural", or Itame 23e or 28e-f show other treumatic evant, it a Medical Examination until be notified at	-	19a. Informant's Name/Relationship			-	and Number or Rural			
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J.	of He of He of Herr item		20a. Method of Disposition 1 ₩ Burial 2 ☐ Cremation 3	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		matory or other pla		ite 200	. Location - City o	Town, State
Ĕ	Page nent ant: It		`4 ☐Donation 5 ☐ Other (Spe		* EreQay Q	unin	July 30	o, 2008 t	Jzulu Tor	El Salvado
Baltimore,	permit. Pages 1 and 2 Department of Health & Importent: If Item 27 I. any injury or other tre 9008.		21. Signature of Funeral Service Lie	VC II	lon A	•	d Funeral			18410 Cedar
H			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	ed the death. Do not en	ter the mode of dyin	ng, such as cardiac or	respiratory arrest,	Triangl	(LICELACT DOCARDOLL
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	₽ ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequence of):					
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X S	law requires that the death certificate be executed es been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Date of de	alivery
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O	Physicien: this certific ral director.	္	1 Yes 2 No	Hospital: 1 ☐ Inpat		ant 3 DOA				ecify)at scene
		-CO	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of In (Month, D tion Fund		Wo		8d. Describe how	injury occurred	
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\leq	= = c	Certification:	4 Homicide determin	building.	njury - At home, farm, s etc. (Specify)	treet, factory, office	-	City or Town, S	State)	Taran Francis Transcon
	pltel nurs a eral I		29a. Certifier 1 ☐ Certifying	Rive	e r st of my knowledge, dea	th occurred at the ti	ime, date and place, a	Potomac		as stated.
	To the Hospitel of within 24 hours aft To the Funeral D completely filled in	edical	(Check only 2 Medicel Ex	xeminer: On the basis and manners	of examination and/or i	nvestigation, in my	opinion, death occurre	d at the time, date	and place, and di	ue to the cause(s)
	o the	Med	29b. Signature and title of certifier	_		29c. Licen	se number	29d	Date signed (Mor	nth, Day, Year)
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			30. Name and address of person w	ho completed cause of	f death (Item 23a) (Type	e, Print)				
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	Regist	rar	JUL 2 2	LUU0	and on he					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 РМ 20, July 2:50 Patricia L. Garrison /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Manchester Longview Nursing Home 8. Date of Birth (Month, Day, Sept 13, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Year) 1945 **Funeral** 1 □ M 2 □XF Months Days Hours Sept Maryland 62 213-44-8136 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 28a-f show iral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Glen Rock PA York 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 5091 Pine View Drive 17327 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Never Married 2 Married white 1 ☐ Yes 2 💢 No Specify: Specify: Baltimore, Maryland 21215-0036 ð 3 Widowed 4 Divorced 'natural", Completed 16b. Kind of Business/Industry is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Bookkeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred E. Monroe Albert P. Lennon Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 360 Utz Drive; Hanover, PA 17331 Daria McMillion dtr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial A Cremation 3 Removal from State permit. Pages 1 Department of I Important: If Ite any injury or ot Parkville, MD 7/25/08 Parkwood Mausoleum 1050 For Roa 21. Signature u eral gervide Licensee 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complet tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performe res 25 1 Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 2 No Hospital: 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death.

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

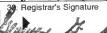
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[Insert of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only and manner stated. the 29d Date signed (Month, Day, Year) 29b. Signature and title of pertified

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of



completed cause of death (Item 23a) (Type, Print)

Rul

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Regist

	1 - State Registrar Cel	rtificate of Death	Reg. N	Reg. No. 2008 2346									
	1. Decedent's Name (First, Middle, Last)		Date of Death Month	av Year	3. Time of Death								
ian cal	Mildrod Anna Waldner Cower		July 18,		12:30P M								
ner	As Equilibrations (If not institution when street and number)	4b. City, Town, or Location of Death		c. County of Death	1								
	Pickersgill Retirement Center	Towson		Balti	more								
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birth	nplace (State or Foreign Intry) MD								
	212-07-4508	5	МО										
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits								
ō			1 X iYes 2 ☐ No										
rect	10e Street and Number	10e. Street and Number 10f. Zip Code 10g											
Ö	615 Chestnut Ave., Rm. 408		0g. Citizen of What Country?										
Jera	11. Marital Status 12. Was Decedent Ever in U.S. 13.	ecify Yes or No-	14. Race - Amer	rican Indian,									
Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	•								
þ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Whi	Lte								
Completed by Funeral Director	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	16b.	Kind of Business/I	ndustry								
n de	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)											
S	စ္ပံ <u>8</u> Se	cretary		siness									
Be	a 17. Father's Name (First, Middle, Last)		e (First, Middle, Maide an Pfeife	,									
2													
	Porconal	ng Address (Street and Number or Rur											
	Cleo Evans -Representative 103	-C Versailles	Circle, T	COWSON, N Location - City or 1	MD 21204								
		natory or other place)		•	Ť								
		c Crematory 7-											
		2. Name and Address of Facility Bra											
	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent	A, 2134 Willow		toad, Z	Approximate								
	shock, or heart failure. List only one cause on each line.				Interval Between Onset and Death								
	disease or condition resulting in death)	heart fail	ure		geans								
	Due to (or as a consequence of):												
ē	Sequentially list conditions, if any leading to immediate cause. Enter Underlying												
Ę	Cause. Enter Underlying Cause (Disease or injury that initiated events												
Examiner	resulting in death) Last Due to (or as a consequence of):												
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Completed by Physician	in the past 12 months? 1 Yes 2 No 9 Unknown	Other (specify)		Month	Day Year								
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þ	Part II. Other significant conditions contributing to death but not resulting in the u				obably 4 Unknown								
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혈	Juliere		24a. Was an autopsy performed2	prior to d	topsy findings available completion of cause of								
			2 🗆 No										
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P.	P 1	1 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how inj	- ' ' -	cify)								
ţi	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	f 28c. Injury at Work? M 1 □ Yes 2 □ No	200. Describe now inj	ary occurred									
fica	2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury: At home, farm, str		28f. Location (Street	and Number or Ru	ıral Route Number.								
erti	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Sta	ite)									
ia O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place	and due to the cause	(s) and manner as	s stated.								
Medical Certification: To	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occur	red at the time, date a	nd place, and due	to the cause(s)								
Σ		29c. License number	29d. [Date signed (Monti									
	If thoughing and	023203	Ju	64 68,3	601								
	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Po (+ Bala	5 1011 >	e > 1 C.									
	31. Date filed (Month, Day, Year) 22. Registrar's Signature	unosi. Petti	or vied ?										
ate rar	acco the Appe	de la companya dela companya dela companya dela companya de la com											

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2:40 P.M PRESTON E. GRABILL JULY 19, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TIMONIUM
If Under 1 Year | If Under STELLA MARIS HOSPICE BALTIMORE Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. **X**□M 2□ F Yrs. Director 88 11/20/1919 MARYLAND 218-03-8895 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Wolfort Event, and to mother traumatic event, the Wolfort Event and the property of the world of the 1 ☐ Yes 2 No Director MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1556 COTTAGE LANE 21286 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status and 2 should be filed within 72 hours after 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 and Mental Hygiene. Is marked other than "natural", or 1 ☐Yes 2 XNo Specify: Completed by Specify. 3 Widowed 4 Divorced WHITE 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE SUPERVISOR 10TH GRADE REFACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNAVAILABLE ဂ UNAVAILABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Pages 1 and مnt of Health and معر 27 ls AMELIA M. GRABILL/WIFE 1556 COTTAGE LANE TOWSON, MD 21286 permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other one. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place)
DULANEY VALLEY MEM. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/23/2008 | COCKEYSVILLE, MD **GARDENS** 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 18521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LEUKEMIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? 1 □Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DDA 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check one) 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23) vpe. Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. ERNESTINE WRIGHT 31. Date filed (Month, Day, Year) egistrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

7:40

2008

GRABIL

			101	partment of Health and M Certificate of Death	Mental Hygie	ne 2008 23463			
	Physicia		1. Decedent's Name (First, Middle, Last) Moric Houston		2. Date of Death Month	Day Year 3. Time of Death			
M.	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
AF.			Seasons Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Randallstown Right If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Baltimore 9. Birthplace (State or Foreign			
п	Funeral Director		509-74-2505 1 M 2 □ F 49 Yrs	Months Dave Hours Min	8. Date of Birth (Month, Day, Ye April 27,	1959 Kansas			
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Logation		10d. Inside City Limits			
	/aryla f sho	or				1 □Yes 2 No			
	r 28a-	irec	Maryland Baltimore 10e. Street and Number	Gwynn Oak 10f. Zip Code	10g.	Citizen of What Country?			
	23a o	Funeral Director	1441 Kirkwood Road	21207		USA			
	er dea items	une	Armed Forces? 1070	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.			
980	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Evandrer must be notified at	by F	1 ☐ Never Married 2X Married 1 XYes 2 ☐ No 1970 If Yes, Give Year or Dates: 1998	1 ☐ Yes 2 XNo Specify:		Specify: Black			
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Maryland	h and h and l ls ma	o W			ural Route Number, City or Town, State, Zip Code)				
	1 and Healt tem 2: other		20a. Method of Disposition 20b. Place of Di	1 Kirkwood Road Gwy sposition (Name of	<u>ynn Oak, M</u> Date 20c	Saryland 21207 C. Location - City or Town, State			
altimore,	Pages nent of I		1 □ Burial 2 M Cremation 3 □ Removal from State	crematory or other place) crematory Inc. 07/1	L8/08 B	Baltimore, Maryland			
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Evancher must be notified #1 once.		21. Signature of Funeral Service Licensee	22 Name and Address of Facility Cremation Society	Of Maryla	and. Inc.			
			Thomas Gregor 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not	299 Frederick Road enter the mode of dying, such as cardiac					
	Physician	8 4	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	injury		Onset and Death			
and the	/Medical Examiner		resulting in death) Due to (or as a consequence of):	• /					
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P.O.	the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)					
	law requires that the death certif as been signed by the attending 2 should be detached for use as	ρ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		co use contribute to the cause of death?			
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Rec		Completed	CONDITION OF TON A MUCALO		24a. Was an autopsy performer	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
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on	th. : After	tion	1 Natural 5 ☐ Pending (Month, Day, Year) Inju		200. Describe flow i	injury occurred			
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ш	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier (Check only Medical Examiner: On the basis of examination and/						
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	- 5 + 5		• Clipel	D60680		7/16/08			
	1,		30. Name and address of person who completed cause of death (Item 23a) (Ty	b Munstreet L	eisterstun	In, MD 21136			
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (TV E. MUNCHUN 75) 31. Date filed (Month, Day, Year) 32. Regetrar's Signature	Sparle					

			Registrar	23a,b,25 per				2. Date of D		2008	23464
-	Physicia	_	Decedent's Name (First, Middle,	Last)				Month	Day		
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1	\$\frac{\partial}{2}		Suburban Hospit 5. Social Security Number	:a1 6. Sex 7. Age (/	In yrs. last birtho	Beth	esda If Under 24 Hr	s. 8. Date of B	8. Date of Birth 9. Birt		place (State or Foreign
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	Director		215-36-4748 Usual Residence of Decedent		68			reb, Z	ر ۱ و ن	740 Mai	yrand
	rland ow at		10a. State 10b. County	10	0c. City, Town o	r Location					10d. Inside City Limits
	Many i-f sh fied	ţ	Maryland Montgo	nm		Rockvil	1 _e				1 ∰ Yes 2 □ No
	r 28a r noti	Director	10e. Street and Number	And I y		10f. Zip Code			10g. Cit	izen of What Co	untry?
	h witi 3a o st be	를 D	1201 Edmonston	Drive		208	51		Unit	ed State	es
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3 6	Pages nent of int: If its iry or o		1 🖾 Buria! 2 ☐ Cremation	3 ☐ Hemoval from State			!	10 2000	, n	1	Massal and
Baltimor	permit. Pa Departmer Important: any injury		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L			n Memorial P					
Ba	permit. Page Department of Important: If any injury or once,		DA A Hala								ville, Inc. ryland 20850
δ 💻			23a. Part1. Enter the disease, or shock, or heart failure. List of	M01532 complications that caused the	ne death. Do no	t enter the mode of dy	ing, such as card	iac or respiratory	arrest,	iiie, ma	Approximate Interval Between
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DHMH 17 Rev 1/2001

			For State Registrar		State c	of Maryla		partment of I Pertificate of			ental F	lygiene Reg. No	2000	3 2	3465
			Decedent's Name (First,	Middle, La	st)		-				2. Date of	Death			ne of Death
Phys /Me			Joseph		C.		Hay	slup			Month July	1 9	y Yea 2008		15 P M
Exan			4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death								4c.	County of De			
and the same of th			810 Old Nort 5. Social Security Number	Old North Point Road Dundalk Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.						ar 24 Hrs	8. Date of		Baltim		ate or Foreign
Funer Directo	-		215-64-8720	1	X M 2□ F		75. last birthday Yrs.	Months Days	Hours	Min.	May 8	Day, Year)	(cyland	_
and and	6	}	Usual Residence of Deceder 10a. State 10b. C			10c.	City, Town or I	ocation						10d. Insi	de City Limits
Mary -f she		호	Maryland Ba	altim	ore		Dunda]	k						1 🗆	Yes 2 No
h the or 28a		Director	10e. Street and Number					10f. Zip Code				10g. Cit	tizen of What	Country?	
th wit			101 Center P.	lace i	Apt 804			212	222				USA		
r dea		Funeral	11. Marital Status		Armed Fo		U.S. 13	. Was Decedent of I	Hispanic C an, Mexic	Origin? (Spe an, Puerto F	cify Yes or Rican, etc.)	No-	14. Race - Ar Black, Wh		ın,
Ite, INIAI YIAIIIU A.I.A.I.S-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. filem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "natural" or insist to in utilias a		হ	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 💢 Div		MYes If Yes, Gi Year or D	2 □ No ive Dates:		1 □Yes 2 XNo	Specif	y:			Specify: V	White	
72 hor		Completed	15. De	cedent's Ed	lucation ide completed)		16a. Dec	edent's Usual Occu	pation	ost of workin	na	16b. K	ind of Busines	s/Industry	
ithin han "		mple	Elementary/Secondary (0		College (1-4or 5+)		e kind of work done DO NOT use retire			<i>'</i> 9				
Hygie Ther t			12 years 17. Father's Name (First, M	liddle Last)		Dr	ry Wall Fi		er her's Name	(First Mid		nstruct Sumame)	ion	
d be f d be f ental ced of		Be	Dores Hayslu		,					a Bre			ourname)		
Lal ylallo ZIZ 2 should be filed withir and Mental Hygiene. is marked other than aumatic event, Inc. In		ပ	19a. Informant's Name/Rel	<u>-</u>	Type. Print)		19b. Mai	ling Address (Street					or Town, State	, Zip Code)	
Ind 2 alth a 27 is ser train			Anna Laird		Mother		101	Center Pl	Lace,	Apt!	506 , 1	Dunda.	lk,MD.	21222	
parimone, Inc permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any Injury or other trau			20a. Method of Disposition	ation 3 □	Removal from	State D	o. Place of Disp cemetery, cr	position (Name of ematory or other pla	ce)	July	^{ate} 23,		ocation - City	•	
it. Pages irtment of ortant: If it		1	4 □ Donation 5 □ Ot		_	Þ		Crematory		2008			timore,		
Department of the series of th	once		Solitature of therail Se	a C	2h			22. Name and Address Connelly 1 7110 Solle	uner ers P	al Hor oint l	me Of Road,	Dunda Dunda	alk,P. <i>R</i> alk,Md.	2122	2
	ı		23a. Part 1. Enter the disea shock, or heart failure	ase, or com e. List only	plications that one cause on e	caused the de		nter the mode of dyi						Approx	rimate I Between
Physicia	_		Immediate Cause (Final disease or condition		a. M	align	ant	Neoplas	m E	+ L	ary	nx		Onset	and Death
/Medica Examine	-		resulting in death)		Due to	(or as cons	equence of):	,			1				
		ē	Sequentially list conditions,		b. Düle tu	(Under Brooks	equarine off:								
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icate be exphysician the burial		edical		•	d										
certific	1	₩e	IF FEMALE:	ant.	23c. If yes, ou	tcome of preg	gnancy						23d. Date of	delivery	
death e atte		Physician/M	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No		4 ☐ Preg	birth 2 Finant at time of		☐ Ectopic pregnand ☐ Other (specify) _	СУ			_	Month	Day	Year
by the	,	hys	9 ☐ Unknown		9 □ Unkr	nown									
es tha		by F	Part II. Other significant co	onditions o	contributing to d	eath but not r	resulting in the	underlying cause giv	ven in Part	t I.			use contribute		
requii		sted									1	Yes 2	□ No 3□	Probably .	4 Unknown
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Completed									pe	las an utopsy erformed? s 2 X No	prior t death	o completior	ings available of cause of
ding Physician; The In. After this certificate hi		Se .	25. Was case referred to m examiner?	edical					26. Pla	ce of Death			, , , , , ,		
hysic this ca ul dire		2	1 ☐ Yes 2 No				☐ ER/Outpati	ent 3 🗆 DOA		Nursing Hon	ne 5□R	esidence	6 XOther (S		ister's
ling P		<u></u>		Pending		of Injury oth, Day, Year,	28b. Time Injury	Wor		_	28d. Descri	be how inju	ry occurred	-	
Athe		licat	3 ☐ Suicide 6 ☐ C	nvestigation Could not b		e of Iniury - At	thome farm s	M 1 C	Yes 2		P&f Locatio	n (Stroot a	nd Number or	Rural Route	Number
alor / s after il Dire		Certification:	4 ☐ Homicide	letermined	build	ing, etc. '(Spe	ecify)	,,				Town, State		, ional i routo	rumbor,
Hospit 24 hour Funera etely fille		Medical (29a. Certifier (Check only one) 1 Ce 2 Me	rtifying Phedical Exar	niner: On the b	e best of my loasis of exam	knowledge, dea ination and/or	ath occurred at the tinvestigation, in my	ime, date opinion, d	and place, a	and due to ed at the tir	the cause(s	s) and manner d place, and d	as stated. lue to the ca	use(s)
To the within To the compl	;	ğ	29b. Signature and title of c	ertifier				29c. Licens	se number	025	71100	29d. Da	ate signed (Mo	nth, Day, Ye	ar)
√			•	In	0	7	. D .		76	427,~	1160	Ju	Ly 21,	2008	
3			30. Name and address of p M&i Tang		22 5.	Gree	ne St	, NGDI	0	Balt	timor	A, I	MD 21)	101	
. Regis	State stra		31. Date filed (Month, Day,	Year) 2008	32. F	Registrar's Sig	nature	W							

			_ FOI	partment of Health and M	lental Hygie	ene	221.66				
			Registrar O	ertificate of Death	Reg	. No 2008	23466 3. Time of Death				
	Physicia		1. Decedent's Name (First, Middle, Last) Kam Hong Ho		Month	19 2008	7:10 A.M				
	/Medic Examin		4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	10				
	ng n transl		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	UTENTA IF Under 1 Year If Under 24 Hrs.	8. Date of Birth	HUNG HYOV	lace (State or Foreign				
100	Funeral Director		214-94-9754 1 [™] 2□F 88 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y Nov • 13	, 1919 Couin	China				
	and ww		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits				
	Maryl I-f sho fied a	tor	MD Baltimore City Baltimor	re			1 ☐ Yes 2 X No				
	ith the or 28s	Direc	10e. Street and Number	10f. Zip Code	1 '	g. Citizen of What Cour	itry?				
	eath w Is 23a must b	Funeral Director	124 W. Franklin Street Apt. 305 11. Marital Status 12. Was Decedent Ever in U.S. 13	21201 3. Was Decedent of Hispanic Origin? (Spe		14. Race - Americ	an Indian,				
ယ္	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Fun	Armed Forces? 1 □ Never Married 2 Married I □ Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White,					
003	ural", o	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	cedent's Usual Occupation	14	Specify: Ch	nines				
-51	in 72 n "nat Medic	Completed	(Specify only highest grade completed) \ (Gi	ive kind of work done during most of work b. DO NOT use retired)		ob. Kind of businessymm	adotty				
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于單	intal H ed oth ed oth	Be	17. Father's Name (First, Middle, Last) Goneping Ho	Siu Hi Ng	e (First, Middle, Ma	aiden Surname)					
KAM HO Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.	2		ailing Address (Street and Number or Run		City or Town, State, Zip	Code)				
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B	limph any		Los frances Mo1411	Services 1 2nd Aver	ue SW G1	en Burnie,	MD 21061				
S-5			23a. Part1. Enter the disease, or complications that caused the death. Do not o shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death				
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a								
	Examiner		Om No Co.	nA							
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8760	cate be executed physician and the burial-transit	dical E	d								
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Box	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pi completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician/Me		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver	ery Day Year				
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Division or Vital Records, P.O.	ires tha signed I be de	ξ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to t acco use contribute to t acco use contribute to t	he cause of death? bably 4 □Unknown				
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ion	ath. or: Afte	atior	1 Natural 5 □ Pending (Month, Day Year) Injur 2 □ Accident investigation	y Work? M 1 ☐ Yes 2 ☐ No							
ivis	I or Attend after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,				
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, do								
	To the Ho within 24 I To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.								
	viti v	2	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, rear)				
	0		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)		my 1-1	aux				
	5		CHOKEN OKETANI, 301 HOSPICE (Dave, alen Born	ne. M	1 21061	!				
	Sta Registi		31. Date filed (Month, Day, Year) U 32. Registrars Signature	will							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Helene Wood Hughes 1:40 P.M July 18, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 8. Date of Birth (Month, Day, Year)
July 12, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days Months Hours 530-10-5989 1 □ M 2 🖾 F 1921 Nevada Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Maryland Baltimore 1 ☐ Yes 2 ☐ No Millers 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of America 2644 Beckleysville Road 21102 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☐No white Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) security guard security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick Leslie Wood Anna Mae Mack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Batzer/ friend 2644 Beckleysville Road Millers, Maryland 21102 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVALUE FUNCTION
CHAPEL BET Air 20c. Location - City or Town, State 20a. Method of Disposition Date July 20, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
eaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dorectal Cayculon 1 Cews disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Month 5 Other (specify)

Physician /Medical **Examiner** Examiner

Physician

/Medical

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Director

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d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

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Department of Health Important: If item 27 any injury or other to once.

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law requires that the death certificate be executed

or Attending Physician: The

To the Hospital

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Division of Vital Records, P.O. Box 687607

Completed by Medical Certification: To Be within 24 hours after death To the Funeral Director: сотрletely filled in by the f

Physician/Medical

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Part II. Other signif	ficant conditions o	ontributing to death but not resul	ting in the underlying cau	se given in Part I.		se contribute to the cause of death? No 3 Probably 4					
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No					
25. Was case refer	red to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2	No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 ☐ DOA	ome 5 ☐ Residence 6 Other (Specify) NOS PUL							
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29a. Certifier (Check only one)	↑ Certifying Ph 2 Medical Exam	ysician: To the best of my know niner: On the basis of examinati and manner stated.	vledge, death occurred at ion and/or investigation, in	the time, date and place my opinion, death occu	, and due to the cause(s) rred at the time, date and	and manner as stated. place, and due to the cause(s)					
29b. Signature and	title of certifier		29c. L	icense number	29d. Date	e signed (Month, Day, Year)					

State Registrar

Day, Year) 31. Date filed (Month

181 Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 1 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** CLYDE 2008 04:43 PM 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Anne Arundel Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 20 1938 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 € M 2 □ F 70 216-36-8123 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Experient must be notified as once. 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 182 Dunlap Road 21122 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harris Elizabeth Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene J. Harris (spouse) 182 Dunlap Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July Date 22 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Baltimore, Maryland etro Crematory Inc. 21. Signature of Funeral Service 2 2 Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Par 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** CARDIAC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LUNG Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown ď 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 24 hours after death. 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 025559 07-21-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAWRENCE MD 1411 MADISON PK. DR. GIEN BURNIE, MD 21001 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State JUL 2 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar		Oldio Ol	war y lari	C	ertificate of		ia memarri	Reg. No. 2	008	234	69
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08-05511 Ryan Healy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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21215-0036 hould be filed within 72 hours after and Mental Hygiene. is marked other than "natural", tife event, the Medical Examiner.	C	Patrick Jos		Hea	lv					Do	nna	Mar	ie	Pfe:	iler		
12 d be fenta narke	∞	19a. Informant's Name/Relation				19b. Ma	iling /	Address	(Street	and Num	ber or R	ural Route I	lumber	, City or	Town, Sta	te, Zip (Code)
D 2 shoul		Patrick J. F			father								nch	est	er,	MD.	21102
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once.		20a, Method of Disposition	icai	У	20b.	Place of Dis	positi	ion (Name				Date	20	c. Locati	on - City	or Town	, State
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Baltimore, permit. Pages I a Department of He Important: If ite	ľ	21. Signature of Funeral Service	e Licens			1	22. Na	ame and A	ddress	of Facility	Eck	hard	t F	'une	ral	Cha	apel P.A
II II De CO		J. Denth Cest	rendt	5		3	29	6 Ch	narı	mil	Dr.	Man	<u>che</u>	ste	r, M	1D . Z	proximate Interval
ysician		23a. Part I. Enter the disease, failure. List only one caus	or compli	cations that	caused the deat	th. Do not en	ter the	e mode of	dying,	such as c	ardiac or	respiratory	anest	SHOCK, U	i ilean	Be	etween Onset and Death
Medical	6 0	Immediate Cause (Final disea		/ultiple Ir	njuries											4	Death
Examiner		or condition resulting in death)			a consequence	of):											
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760, ficate bo g physic the bu	W/	IF FEMALE: 23b, Was decedent pregnant in	the		s, outcome of pro e birth	egnancy	Fet	tal death	3	Ectop	ic pregna	incy		Mor		Day	Year
68 Se as	ian	past 12 months?			egnant at time of			her (Spec	ifv)		, ,						
P.O. Box 687 s that the death certific gned by the attending I e detached for use as the	sic	1 Yes 2 No 9	Jnknown	-	known			101 ()	-								
the d	Phy	Part II. Other significant con	ditions	contributing	g to death but no	t resulting in	the u	ınderlying	cause (given in P	art I.						cause of death?
that oned the detay												1	Yes	2 🗸 No	3F	robably	4 Unknown
ords, P.C w requires that as been signed I	Completed by												Was an		24b. Were	autops	y findings available
ord w rec	를 를												autopsy perform		death		oletion of cause of
ecc he la ste hz age 2	🖺	-										1 🗸	res 2	No	1 🗸	Yes	2 No
tal Rection: The certificate ector, page		25. Was case referred to med	ical					2	26.Place		(Check	only one)					
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rate death. The Invector: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Be G	examiner? 1 ✓ Yes 2 No	F	lospital: 1	Inpatient 2	ER/Outp	atient	3 D	OA	Other ₄	Nursi	ng Home			6 🗸 O	ther: So	ene
of V ing Phy After th	은	27. Manner of Death		28a. D	ate of Injury onth Day Year) 8, 2008	28b. Tin	ne of I	Injury 2	28c. Inju	ıry at Wo	rk?	28d. Desc	ribe ho	w injury o	occurred collision	n witl	n trailer
nding th.	<u> </u>		ending		8, 2008	0953 h	rs		1	Yes 2	No						
ivisior or Attencafter death Director:	cat		vestigati	28e F	Place of Injury - A	t home, farm	, stree	et, factory	, office	building,	etc.	28f. Loca	tion (St	reet and	Number o	r Rurai	Route Number, City
Divi alor safte d Dir	Certification:	d d	could not etermine	pe	ify) Major Ro							Route 31	wn, Sta at Wi	ndsor D	rive, We	stmins	ter, MD
Spite hour mera y fill	ပီ	4 Homicide 29a. Certifying	Dhomini	an. To the	host of my know	ledge death	occui	rred at the	e time. d	date and r	olace, an	d due to the	cause	(s) and m	nanner as	stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buril.	Medical	(Check only one) 2 Medical	g Pnysici Examinei	:On the ba	sis of examination	n and/or inv	estiga	ation, in my	y opinio	n, death	occurred	at the time,	date a	nd place,	and due	to the c	ause(s)
To the within To the comp	edi			and mann	er stated.					se numbe			Т				Day, Year)
	2	29b. Signature and title of ce	N	0 11	0.0					.M.E.			1	July 1	9, 2008	1	
		Maryone	Uh	eldh	ul												
<u> </u>		30. Name and address of per	son who	completed	cause of death (I	tem 23a)				20141	EO 140	21201					
2		Margarita Korell M	D As	ssistant N	Medical Exar	niner 1	11 P	Penn St	reet, E	saiumo	re, IVID	21201					
	State	31. Date filed (Month, Day, Y	gar)	008 32	. Registrar's Sig	natur	15	1									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Marylar		partment of Hea e <i>rtificate of De</i>	ith and Mental H <i>ath</i>	Iygiene 200	8 23471
	Physici		1. Decedent's Name (First, Middle, Las	HY HF	146	VIE	2. Date of Month	Death Death Death	3. Time of Death
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give GOOD SAMARITAN I 5. Social Security Number 6. St	NURSING HOME 9x 7. Age (In yrs	. last birthday Yrs.	y) If Under 1 Year II U	PRE CTTY Under 24 Hrs. 8. Date of (Month,	Day, Year)	Birthplace (State or Foreign Country) MARYLAND
	ס		214-18-0750 Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or I	Location	6/8/1	921	10d. Inside City Limits
	Mary a-f eh	to	MD BALTI	MORE	PARK	VILLE			1 ☐ Yes 2X No
	ith the	Direc	10e. Street and Number			10f. Zip Code		10g. Citizen of What	t Country?
	s 23a	erai	8663 OAK ROAD	12. Was Decedent Ever in	15 13	21234		USA No- 14 Race - A	American Indian,
21215-0036	permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Dependent of Health and Mental Plygiene. Dependents if Item 27 is marked other then "naturel", or Items 23a or 28s-f ehow simportents if Item 27 is marked other then "naturel", or Items 23a or 28s-f ehow apply injury or other treumatic event. I'm Medical Examinar mant be muffled at another.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0.0.		nic Origin? (Specify Yes or exican, Puerto Rican, etc.)	Black, V Specify:	Vhite, etc. WHITE
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12	filed withir Hygiene. ther then int, tre Mi	ошо	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or 5+)		ILE CLERK		MANUFACI	
	be filed ital Hygi of other event.	BeC	17. Father's Name (First, Middle, Last)			18.	Mother's Name (First, Midd	dle, Maiden Sumame)	
ylaı	should b ind Ments marked umatice	10	GEORGE VOGEL		40. 14		MARTHA BEND		to Tip Code)
Maryland	d 2 sh th and th and t7 is rr treurr		19a. Informant's Name/Relationship		194505	vaniminus est estatus	Number or Rural Route Nui		SECURE S
	es 1 end of Heaith f item 27 r other tr		SHIRLEY HALES/DAUG 20a. Method of Disposition	20b.		TINGLE AVE. position (Name of rematory or other place)	Date	ACH, DE 19 2 Jc. Location - City	or Town, State
altimore,	Pege ment cent: if		1 X Murial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	PA	ARKWOOL	CEMETERY	7/23/2008	EALTIMORE	, MD
Ball	permit. Pege Depertment importent: if importent: if eny injury or once.		21. Signature of Funeral Service Licen	500		22. Name and Address of	Facility THE JOHN	SON FUNERAL	HOME, P.A.
			23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the decone cause on each line.		enter the mode of dying, su	0	y arrest,	Approximate Interval Between Onset and Death
	Physician /Medical xaminer		disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):	brillatio	aeeiden n	Л	6 Houlls
68760,	icete be executed physicien and s the burial-transit	edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse					
P.O. Box 68	death certii e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ₹ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	3 Ectopic pregnancy 5 Other (specify)		23d. Date o Month	f delivery Day Year
	law requires thet the es been signed by th 2 should be detache	þ	Part II. Other significant conditions of	ontributing to death but not re	esulting in the	underlying cause given in			te to the cause of death?
of Vital Records,	The ete h	Completed			· · · · ·			utopsy prio erformed? dea	re autopsy findings available r to completion of cause of th? Yes 2/20/vo
Vita	Physicien: Th this certificete ral director, pag) Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2	TER/Outros	Othor	Place of Death (Check or		(Canada)
n of	두 등 등	on: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Injury al		ibe how injury occurred	Specify
Division	or Atten after deal Director in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined					on (Street and Number of Town, State)	or Rural Route Number,
_	Hospital 24 hours Funerel I stely filled	Medical Co		ysiniam: To the best of my kininer: On the basis of examinand manner stated.					
)	To the within 2 To the comple	Me	29b. Signature and title of continer	K. Tup	end	29c. License nu D 3	066 l	29d. Date signed (A	Month, Day, Year) 21 2008
	4		30. Name and address of person who 5 60 l week k	completed cause of 3 and (It	em 23a) (Typ	Balline	0661 se. Hd-	21239	1
2	Sta Regist		31. Date liled (Month, Pay Year) 20	Registrar's Sig	nature	all .			

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** ACKSON Month Juli 16:52 PM 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAMARITAN HOSPITAL NIF Baltimore If Under 1 Year Birthplace (State or Foreign Country) last birthday If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** 1**2**M 2□F Days Hours 215-90-51 Director raryland ORIL Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Evandrian must be notified at 1 kes 2 No Director Trmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 □Vo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) or ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a ltem 27 is 32nd-St. 10 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State -21-0 4 ☐ Donation 5 Other (Specify) 21. Signatur Funeral Service 22. Name and Address of Facility 23a. Part. E. terune disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line.

Immedia Cause (Final disease or condition resulting in death)

a.

Due to prose a consequence of the condition resulting in death) Approximate Interval Between Onset and Death **Physician** /Medical Due to for as a consequence of): Examiner baCHEREMIA Sequentially list conditions, a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RINAL LIGIAGE ENDOCARDITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed SEIZU RES 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy page performed 1 □Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ö To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES-000 July 14, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

SAMARITAN HOSPITAL

Shayur Good

5601 LOCH RAVEN BLUD BALTIMORE MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician Year AM Jones 11:55 2008 /Medical 20 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Memorial Hospital Ba Himore Security Number 20 • 8889 Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 85 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MID 1XYes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 airlawn USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 MONo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Black Specify: Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2th arade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clavence Bates Many 2 19a. Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Court Ellicott City Madelaine Jones atodu 1a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 DRemoval from State Baltimore National 07 Baltimore, MD 08 4 Donation 5 Dother (Specify) 25 21. Signature of Funeral Service License aughn C. Greene Funeral STVO an Randaistown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician hour /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed diff attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) the 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ate has bage 2 s autonsy performed? 1□ Yes 2 1 certificate 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 💢 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours. the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 ho

To the Function

completely i (Check only one) 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Muhannao

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

nion

Memorial

HaFi M. 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JONES 20080005 OBERT 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner Baltimore City** N/A The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) APR 23 1951 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Months Days Hours Min. 57 Tennessee 412-94-6718 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show 1 X Yes 2 □ No Director N/A MD Baltimore 10e. Street and Number 10f, Zip-Code 10g. Citizen of What Country? ŏ must be 2427 Ridgely Street 21230 23a USA Funeral Items ; 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after of the of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or Ite the Medical Examiner 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 XNo Specify: \$ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver 12 Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ William 1 am Jones Leona Mays ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any Injury or other trau Emma Jones - wife 2427 Ridgely Street, Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 7/18/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Steven H. Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician intravascular lisseminated disease or condition resulting in death) → Medical Due to (or as a consequence of) Examiner ulcostasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence or) clast CMSI resulting in death) Last Due to (or as a consequence of) Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Tectopic pregnancy ☐ Live birth Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Tes 0 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 1 TYes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 1 🗌 Yes 2 ER/Outpatient 3 🗆 DOA 6 Other (Specify) Inpatient ၉ 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

The law requires that the death certificate be executed physician and as the burial-trans Division of Vital Records, P.O. Box 68760, for seen signed by the a should be detached page 2 s certificate has Attending Physician: After this s after death. filled in by the 5 Hospital

the Maryland

death with

Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral Completely filled

State Registrar

Medical

31. Date filed (Month, Day, Year)

(check only one)

29b. Signature and title of certifie

MON 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

600 North Wolfe St. Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

200 X

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician lilliam Year /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HART HERITAGE
5. Social Security Number 6. Sex Street HARFORD. If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Hours Min. Days Yrs. 92 212-07-3555 Director 02/25/1916 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director MD Harford Street 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3708 Grier Nursery Road 21154 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, Ite Medical Examina once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify. þ White Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Insurance Agency College (1-4or 5+) Self-Employed ģ 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Teresa Williams William E. Jasper, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Jasper/ Son 206 Rhineforte Dr. Churchville, MD 21028 20b. Place of Disposition (Name of cametery, crematory or other place)
Evans Funeral
Chapel - Bel Air 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 07/21/08 Forest Hill, MD 4 □ Donation 5 □ Other (Specify) Chapel-21. Sign Ture of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a Par 1. Enter the disease, or completations that caused the shock, or heart failure. List only one cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Imm diete Cause (Final disease or condition resulting in death) **Physician** -429 (suchn 4RANS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending j IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) ed by the 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has 24a. Was an autopsy performed certificate 2 🖃 No 1 □Yes Hospital or Attending Physician: -24 hours after death. Funeral Director: After this certifica director, 25. Was case referred to medical Be ASSISTED 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 1 Yes 2 No CARE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 39889 2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

ALFRAD

32 Registrar's Signature

SPANUS MA

r's Signature

415 W. MACPHAIL

Bel pin 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 981 7-25-08 vt State of Maryland? Department of Health and Mental Hygien 2 0 8

Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 9 Physician Month Year 6:30 AM PATRICIA S. JENKINS -08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RUXTON BALTIMORE MANOR CARE-RUXTON 8. Date of Birth 1918 Alug. 7, 1917 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign W. VA. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 XF 90 Yrs 235-14-8817 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28e-1 ehow other treumatic event, the Madical Examiner must be notified at Baltimore County 1 ☐ Yes 2 No Baltimore Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21206 4800 Kenwood Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other then eny injury or other treumetic account. Elementary/Secondary (0-12) College (1-4or 5+) Homemaking - Own Home 12 yrs. Homemaker 1 yr.17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Griffith Alphonse R. Swain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Kenwood Avenue Baltimore, Md. 21206 Katinka J. Finn (Daughter) Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Gate of Heaven Cem. X № Burial 2 □ Cremation 3 □ Removal from State 7-21-2008 Silver Spring, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Lassann Fürferal Home 7401 Belair Rd. Baltimore, Md. 21236 E. J. Jass a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ementa /Medical Due to (or as a consequence of): **Examiner** Perten Sici Sequentially list conditions, if any locating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last r as a consequence of): Examiner death certificate be executed burial-transit Mascular Accident erema Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Noknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🕍 No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel within 24 hours as To the Funerel E 1 Secretifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) o E. Timenium rd. #209 Timonium, MD 21093 Yrus Régistrar s Signa 31. Date filed (Month, Day, Year) State JUL 2 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 108 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOYNER PM 2008 11:10 JULY /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SAMARITAN MOSPITAL BALTIMORE n/a House 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. J. Month 16.4, Year 923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 219-18-5713 1**☑** M 2□ F Marvland Director Usual Residence of Decedent 10c. City, Town or Location ms 23a or 28a-f show must be notifled at 10d. Inside City Limits MD Baltimore Parkville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd., Apt. 1428 21234 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23; ury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 No If Yes, Give 143-146 Year or Dates: 1 Never Married 20 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Client Rep/Sales Investments 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Lloyd Joyner, Sr. Geraldine ٩ Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Daly-Stepdaughter 13807 Ansari La., Baldwin, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ortant: If itel 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 7/23/08 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22 Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): SEPSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐Ectopic pregnancy Month Day signed by the a 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ MBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Yo autopsy perform 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 1 Inpatient s after dea... 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred *Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0058913 14amons 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN RANE OF MANISHA BAHL, MD RAI 71 MARIE MA

Registrar DHMH 17 Rev 1/2001

State

MANISHA 31. Date filed (Month, Day, Year)

2008

22

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5:10 P M Sulv Margaret Helen Keggins 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BURNIE ARUNDEL Battimore Washington MEDICAL CENTER GLEN ANNE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F 212-52-4406 86 07-15-1922 Director Canada Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examinar must be a difficulat Director 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 396 Phirne Road West 21061 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be L. Thompson Emma Hein ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as important: if item 27 is any injury or other trau Pages 1 and 2 Mrs. Kathleen Sybert / daughter 946 Heritage Drive; Gettysburg, PA 17325 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vets. Cem. 7-22-2008 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Venu disease or condition resulting in death) /Medical Lue (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physiclan for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 3 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ ficate has been się rr, page 2 should b 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1) Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Tight Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the I within 2

DHMH 17 Rev 1/2001

State

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Rrint),

29d. Date signed (Month, Day, Year)

2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 18 JOHN CHARLES ARNOLD KNELL, SR. 02:47 AM JULY 2008 4c. County of Deatl 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ST AGNES HOSPITAL TIMORE If Under 8. Date of Birth (Month, Day, OCT • 4 , 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1**™**M 2□F Months Days Hours Min. MARYLAND 213-34-3327 69 1938 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County BALTIMORE X□Yes 2□No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 1626 INVERNESS AVENUE 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗌 No 1 ☐ Yes 2 ☐ No Specify Specify: WHITE 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST MACHINIST 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY SIMMON JOHN KNELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY CARR 40 ROBIN HOOD RD. HAVRE DE GRACE, MARYLAND 21078 step son 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Nourial 2 Cremation 3 Removal from State GARRISON FOREST JULY 24, 2008 OWINGS MILLS, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MCCULLY POLYNIAK FUNERAL HOME PA ONACO 130 E. FORT AVE. BALTIMORE. MARYLAND 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) C. DIFF COLITIS Due to (or as a consequence of): KLEBSIELLA PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last RIGHT MEDDLE CEREBRAL Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CONGESTIVE HEART FAILURE 1 Yes 2 No 3 Probably 4 Noknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes No 24a. Was an CORONAKY ARTERY DISEASE autopsy performed? Yes 2 No LARYNGEAL CANCER 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

The law requires that the death certificate be execu Physician: this

P.O. Box 68760,

or Vital Records,

Division

2107

6

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

<u>ک</u>

Completed

Be

ပ

Examine

d other than "natural", or items 23a or 28a-f sho efent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic effent, the Medical Examiner must be now Injury or other traumatic.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

the Maryland

/Medical

T State

Hospital

the

Physician/Medical þ Completed Be 2 after death. I Director: After ti Certification: in by within 24 hours a Medical

29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation

6 ☐ Could not be

determined

29c. License number P20966

1 Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

18

2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eyad AlSheikh, 900 S. Caton Ave

900 S. Caton Ave, Baltimore, MD 21229

31. Date filed (Month, Day, Year) JUL 2 2 2008 . Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** Paul J_{u}^{Month} 21 Ε. Kincaid Sr. 2008 1:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Healthcare Hammonds Lane Brooklyn Park Anne Arundel County Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day) **Funeral** Days Hours Min. 1.**⊠** M 2□ F 09, 1928 213-22-4113 80 West Virginia Director Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be rediffed at 1 ☐ Yes 2 No Woodstock Directo Maryland Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21163 U.S.A. 10635 Breezewood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MayYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify.White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify. 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, it a Menta once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Milkman Dairy Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be S. Elsie Walk Robert Kincaid ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10635 Breezewood Drive, Woodstock, Maryland 21163 Sarnook (Daughter) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 07-24-08 Brooklyn Park, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Pervice Licens 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21225 237 East Patapsco Avenue, Baltimore, Maryland Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Muocordial (no barchion /Medical Due to was a consequence of): Examiner 2 JON BOLO if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence sician and burial-transit law requires that the death certificate be executed Exami Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Year Day 5 Other (specify) signed by the a P.O. 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed Yes 2 1 □ Yes 1 Yes or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural
2 Accident (Month, Day, Year) 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) ditle of certifier 29c. License number 29b. Signature MD 3462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+1 Glen Burnie MD 21061 JudeMunescs 1842 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 2350 PM Tauheed Ali Khan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) July 15, 2008 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Months Days 1 XM 2 □ F unk Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10h County 28a-f show notified at 1 ☐ Yes 2 ☐XNo Director Waldorf MD Charles the 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ŏ death with must be 20601 United States 2482 Breakwater Court 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian or items Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite the Medical Examiner 1 Yes 2 If Yes, Give 2 No Never Married 2 Married Asian 1 ☐ Yes 2 🗓No Baltimore, Maryland 21215-0036 Specify. Specify: ۵ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Not Self Supporting Dependent 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be Shahid Ali Khan Nasra Khan ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2482 Breakwater Court, Waldorf, MD 20601 Shahid Ali Khan, Father 20b. Place of Disposition (Name of cemetery, crematory or other place)

Aama Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition Department of H Important: If Ite any injury or otl once. 1 N Burial 2 ☐ Cremation 3 Removal from State 07/20/2008 Stafford, Virginia 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Licensee M01113 22. Name and Address of Facility Aden Muslim Funeral Service June 17 1242 Easy Street, Woodbridge, Virginia 22191 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Non **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of, physician and is the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) n signed by the at 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 70 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has b director, page 2 s 2 X No 2 **K** No 1 Tyes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 KInpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA ဂ After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) Bernadetto 600 North Wolfe St, Baltimore, MD, 21287 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) KYLE **Physician** 2.2 4 AM SALLY 2008 Jul 17 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore City The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec . 27 , 1948 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2X F 59 MD 220-54-6224 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f sho her must be notified at Baltimore Baltimore 1 ☐ Yes 2 ☐ No MD Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21224 USA 7935 Wynbrook Road Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian. Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No White Specify: þ 3 Widowed 4 □ Divorced Year or Dates "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Office Manager 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Retail Elementary/Secondary (0-12) College (1-4 or 5+) ath and Mental Hygiene. 27 Is marked other than 'r traumatic event, the Me 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles R. Hoffman Eunice Horne ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7935 Wynbrook Road Baltimore MD 21224 Jonathan Wood / son t of Health item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State = ₽ 19/08 permit. Page Department of Important: If any Injury or once, Baltimore MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hemorrhagic shock 1.5 hours **Physician** /Medical Due to (or as a consequence of): gastrointestinal bleeding **Examiner** 3 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed coaquiopathi Due to (or as a consequence of) physician an as the burial-tr Division of Vital Records, P.O. Box 68760, cirrhosis Physician/Medical attending p 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 | No 1 Tyes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital 2 Νo 2 ER/Outpatient 3 DOA Inpatient မ 27. Manner of Dea 1 Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation After (Month, Day Year) Injury 1 Tes 2 No Accident within 24 hours after death

To the Funeral Director: A
completely filled in by the f 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ∠ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed Month, Day, Year)

medical address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

17,2008

Physician /Medical Examiner

Director

Funeral

Director

Funeral

2

Completed

Be

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la or 28a-f show t be notified at or items 23a caminer must be "natural", or item: edical Examiner n other than "natu vent, the Medical

Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. item 27 is marked othe other traumatic event, Health and New 27 is man permit. Pages
Department of
Important: If it
any injury or o

Division or Vital Records, P.O. Box 68760, attending physician the þ signed l has certificate

Baltimore, Maryland 21215-0036 Marcia Gerhold - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 7-15-08 21. Signature of Euneral Se 22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying tauce (Liceace or lifer) that initiated events resulting in death) Last Examiner Due to (or as a consequence of): as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 DEctopic pregnancy ło in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 24a. Was an autopsy performed 1☐ Yes 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No P 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month John H. Kirby 12, 12:15P M 2008 July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Future Care Northpoint Dundalk Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) 8 – 1 – 1911 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Days 217-05-6871 $\stackrel{niry}{\mathrm{MD}}$ Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 7246 Gough Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2☐ No Specify 3 ₩idowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Martin Marietta Maintenance 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marcia Elliott Tucker Richard Henry Kirby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7246 Gough Street, Baltimore, MD 21224 20c. Location - City or Town, State Baltimore, MD

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Day

Year

21222

23d. Date of delivery

Month

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	-	rtment of F <i>tificate of I</i>				0.0	00101
			Registrar 1. Decedent's Name (First, Middle, Last)		inicate or i	Death	2, Date of Dea	Reg. No.2	US^{-1}	23484 3 Time of Death
п	Physicia	an					Month	Day	Year	or M
-	/Medic		ALBert Hash 4a. Facility Name (If not institution, give street and number)		4h City Town o	r Location of Death	July	1 8 2c		(0:35 M
•	Examin	er					ı			
	5		5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs.	3. Date of Birt		9. Birthplace	e (State or Foreign
	Funeral Director		383-12-0406 12 M 2□ F 86	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Country	MI
			Usual Residence of Decedent				July 3	0 (44)		
	/lanc		10a. State 10b. County 10c. City	y, Town or Loc	cation				10d.	Inside City Limits
	Mar B-f st	ţo	MD BALTIMORE R	ROCKDAL	.E					1 ☐ Yes 2 🛣 No
	r 28g	ire	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Country	?
	3a o	a D	8307 LAGES LANES			21244			USA	
	ms 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of H Yes, specify Cuba		pecify Yes or No	14. Race	- American	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "befined Evantizer must be notified at	by Fu	Armed Forces? 1 □ Never Married 2 💢 Married 1 □ Never Married 2 💢 Married 1 □ Yes 2 💆 No If Yes, Give Year or Dates:		rYes, specify Cuba I∐Yes 2∭X No	Specify:	o rican, etc.)	Specify:	k, White, etc. WHI	
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و	nt of nt of nt of nt of		1 N Burial 2 Cremation 3 Removal from State	emetery, cřem	natory or other plac		1/2008	BALTIM		,
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Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee		. Name and Addre 3900 REIS					
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Check only (Ch							
	o the l	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. Licens			29d. Date signed		
	- S F O									
	/	ŀ	30. Name and address of person who completed cause of death (Item			9085		July	5 2	1008
	2					COURT	Recen	0	21	133
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signat	ture /	ast 1			_		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per 2881 07/21/08dhb 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 121 PM LYONS MAY PATRICK JOSEPH **3**2 208 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWAR E. WATERSVILLE ROAD AIRY Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 215-68-8819 59 Yrs 1956 MIZCH 31 WASHINGO Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County show ns 23a or 28a-f shor must be notified at 1 ☐Yes 2 No MD MT. AIRY (Samoh Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA WATERVILLE ROAD 217 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or items Medical Examiner mu 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: WHITE Completed by 3 ₩Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOTIVE COLLISION PLANT AUTOMOTIVE 13 permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If Item 27 is marked other th
any Injury or other traumatic event, the
once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH M. LYONS MARY C. PARVIER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MT. AIRY MD 21771 E. WATKISUILLE 908 RODS MARY LYONS DODSON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State HANDUIS, MARYLAND AN 37 300 A ARDINT COLINATORY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
ARDFAT USENATION SURVIUS 21. Signature of Funeral Service Licensee 21076 sour 7532 COUNTRILLY DRIVE MAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WEMES **Physician** MEUMONIA ASPIRIRATION /Medical Due to (or as a consequence of) Examiner BRAIN INJUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDIC Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Subject operator of motor-cycle that overturned. - Natural 5 Pending investigation 1 Tes 05/15/2002 1:10 a.^M 2**√** No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Interstate 70 near Woodbine Rd, Lisbon, MD 4 ☐ Homicide Roadway

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Medical State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) evelya Jackson MD

2 1 2008

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

3416 OLD-DWOOD CT. 32 Registrar's Signature

and manner stated.

TSI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

STE 200

29d. Date signed (Month, Day, Year)

may 23, 2008

OCHEY WY 30837

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. N 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 08 Physician Month Loretta Jean Lee 230 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAHIMORE ROSEDALE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct. | Month, Day, Year | 934 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F West Virginia Months 73 Director 218-32-0176 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10h County 10d. Inside City Limits "natural", or items 23a or 28a-f show N/A Maryland Baltimore 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 3514 Mary Avenue 10f. Zip Code 21214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 □ Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) filed withir Hygiene. College (1-4or 5+) 11 Microcircuit Assembly Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Harry Lee Mabel Piccinotti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important; if item 27 is
any injury or other trau Linda Hodges, daughter 2813 Lakeview Ave. Sykesville, MD. Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State West Arundel Crematory 07-22-08 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21. Signature of Funeral Service Licensee 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DAYS /Medical Due to (or as a consequence of): Examiner NOLIMONIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buris Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 🗌 Yes 2 **X**No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 XNo 24a. Was an has autopsy page perform ABETES certificate 2 X No Physician: 25. Was case referred to medical examiner? funeral director, Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; /
completely filled in by the f 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and ittle 29d. Date signed (Month, Day, Year) RES 0000

State Registrar 30. Name and address of person who

31. Date filed (Month, Day,

SHEHY

Year.

DHMH 17 Rev 1/2001

9000 FRANKLIN SQUARE DRIVE BALTIMURE MARYLAND 21237

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23487 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 16:21 M Leonard July 2008 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 1 ▼ M 2 □ F 9, Maryland 213-28-0980 Mar. 1932 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10h County 1 Type 2 N No Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21222 United States 8206 Beach Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1- Yes 2 No 1. Yes 2 [If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced Korean White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Engineer 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Lippa Ruth Watts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8206 Beach Drive Dundalk, Maryland 21222 Maria R. Lippa (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stanislaus Cemetery 7/22/2008 Baltimore, Maryland 21. Signature of Juneral San 22. Name and Address of Facility 00 Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on of Approximate Interval Between Onset and Death used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, denocarcinoma Due to (or as a consequence of) Due to for as a consequence of Due to (or as a consequence of) 23d. Date of delivery

Physician /Medical Examiner

Physician

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r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

death with

The law requires that the death certificate be executed attending physician and I for use as the burial-transit been signed by the a should be detached has bage ; certificate funeral director, this 24 hours after death.

Funeral Director: After t or Attending the ģ

Examine Physiclan/Medical \$ Completed Be မ Certification:

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 2 PNo 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗌 Yes 2 = No 2 ER/Outpatient 3 🗆 DQA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

DYI

To the Hospital o within 24 hours at To the Funeral D

filled in

State Registrar

Medical

Hernang Stebes 31. Date filed (Month, Day, Year)

2 2 2008

30. Name and address of person

JUL

32. Registrar's Signature

no completed cause of death (Item 23a) (Type, Print)

RES-000

600 North Wolfe St, Baltimore, MD, 21287

Charles William Lanf 08-04699 Please

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physicia		Registrar 1. Decedent's Nan	ne (First, Middle, l	Last)							Date of D					of Death	\neg	
ledical Exami	ner	Charles	William	Lauf							June 18	, 2008	3			0 hrs		
		4a. Facility Name 500 Harbor	(if not institution, r View Drive	give street and nu	imber)	4	Baltimore		ation of De				4c. County o					
Funeral Director		5. Social Security		Sex	7. Age (In yrs. Ia		If Under 1 \ Months E	_	Under 24	Min.	8. Date of		wdd/yyyy 955	Foreig		State or un	ık	
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menlal Hygiers 27 is marked other than "natural", or items 23a or 28a-f sho manatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Mari		Associat F	cedent Ever in U. orces?		Decedent of es, specify Cu					No-	White	e, etc.		an, Black,		
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Baltimore, MD 2 permit. Pages I and 2 should Department of Health and M Important: If item 27 is m injury or other traumatic of			Cremation	3 Removal f	rom State	Place of Disposi crematory or oth		cemete	ery,	ı	Date	20	c. Location	- City or	TOWN, 2	itate		
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T. ĕ. is	Š	29b. Signature ar	nd title of ceptifier		stateu.		29c. Li	cense r	number			2	9d. Date sig	ned (M	onth, Da	y, Year)		
			4	las			C	.C.M.	E.			J	une 19, :	2008				
		30. Name and ad	Idress of person v		use of death (Iter	n 23a)												
		David Fow	•	Chief Medical		111 Penn S	treet, Balt	mbre.	, MD 21	201								
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23489 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LEW,5 ILDRED 2008 2:10 /Medical . Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Number 7. Age (In yrs. last birthday) Months Days Hours Min 1 □ M 2 🛱 F 83 Yrs. 21, 1925 MD Director May Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b County 10c. City, Town or Location 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Mexical Exp. it we must be notified at 1 ☐ Yes 2 No Director MD Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2902 Ritchie Ave. 21219 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>م</u> white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. Labor Relations Specialist Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Columbus Rigler Minnie Mabel Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Jeannie Diane Lewis/daughter 4037 Hunt Crest Rd. Jarrettsville, MD 21084 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Springfield Cemetery Co.7/22/08 Sykesville, MD 22. Name and Address of Facility Lemmon Funeral H 10 W. Padonia Rd. Home of Dulaney Valley, Inc. 1. Timonium MD 21093 Clary isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Approximate Interval Between Onset and Death or heart Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of) RESPIRATORY FAILURE Examiner CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner law requires that the death certificate be executed 45BESTOSIS physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 1 ∐Yes 2 No 9 ☐ Unknown 5 Other (specify) Ö ed by the detached ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Probably 4 Unknown ORTHOSTATIC HYPOTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 No 2 🗆 No 1 □Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c, Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A 2 Accident investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier igth D63639

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Registrar
DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POTHU

31. Date filed (Month, Day, Year)

NAGABHYRU MD. 9000 FRANKLINSQUIARE DRIVE BAHIMORE, MARYLAND 21237

State of Maryland / Department of Health and Mental Hygien 0 0 8
Amend 26, perverbal ME G881 7/22/18 TT
Certificate of Death
Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 14, Carlos Lopez Ju1y 2008 1459 hrs Juan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Charles Potomac River Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1X M 2 ☐ F December 25,1972 Director El Salvador 223-91-4342 36 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelib and Mental Hygiene. Important: if Item 27 is marked other then "natural", or iteme 23s or 28s-4 show eny figury or other treumatic event, the Madical Exerting Charles the rivilities at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Directo Virginia | Prince William Woodbridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22191 El Salvador 1611 Maurice Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 15 Yes 2□ No Specify: El Salvador Specify: Hispanic ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Construction 8 Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Santos Quantanilla Francisco A. Ramirez 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ana Marina Romero, Wife 1611 Maurice Drive Woodbridge, VA 22191 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) EreQay Qunin July 30, 08Uzulu Ton El Salvador 21. Signature of Funeral Service Licensee 22. Name and Address of Facility A Dignified Funeral & Cremation Obert our 18401 Cedar Drive, Triangle, VA 22172 na 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Drowning /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy ned by the atter Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 X Yes 2 □ No 2 No 1 Yes s after deau...
ret Director: After this cer...
- 4 in by the funeral director, pr or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \cancel{R}$ Other (Specify)at scene Hospital: Certification: To 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of **Found** 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 5 □ Pending investigation Founduly 1 Natural 1 ☐ Yes 2 🗷 No 2 🗷 Accident Subject drowned 1459 14,08 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Potomac River, Newburg, MD River within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME on mu July 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Assistant medical Examiner III Penn St. Baltimore, mb Donna M. Vincerti, MD 31. Date filed (Month, Day, Year) 32. Rafistrar's Signature State 2008 Registrar DHMH 17 Rev 1/2001 DOME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 2008 Anne F. Lappe-Perry 5:13 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Oak Crest Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√□ F Months Days Hours 278-24-3197 79 Director Sept 1928 Maryland 28, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Micdical Examinar must be natified at Baltimore Baltimore Md. Director 1 ☐ Yes 2X☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd. #3209 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill hand Mental H Adolf Feustle M. Anne Bollinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau Ms. Martha Lappe/ Daughter 315 Taplow Rd. Baltimore, Md. 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 № Burial 2 Cremation 3 Removal from State Dulaney Valley 7-25-08 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cerebrovascular occident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 🗆 Unknown 9 Unknown signed t Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 ☐Yes 2 ☐No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Ahne Pery Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

ital

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Division

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DIXONMO

2 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walther Blud

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Parhville, MD 21234

29d. Date signed (Month, Day, Year)

08-05518 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 23492 Kameron Chase Ladra State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Day July 18, 2008 Kameron C. Ladra Medical Examiner 0609 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5 Bryce Court **Baltimore County** Nottingham 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 215-71-0422 Months Foreign Country) Days Hours Director 1 X M 2 F Oct.27,2004 3 MD Usual Residence of Decedent any 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show MD Baltimore Yes 2 XNo Nottingham death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5 Bryce Court 21236 23a Funeral 11. Mantal Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian, Black be 1 X Never Married 2 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Married Yes è White Yes, Give Yea Yes 2 X No specify: Divorced Specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nat
injury or other traumatic event, the Medical Exa during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n/a 0 n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emil Ladra Be Angalee Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emil Ladra / father 5 Bryce Court Nottingham MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Horning of Hill Cemetery 7/23/08 Baltimore MD cremation 3 1 X Burial Removal from State Donation 5 Other Specify: 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 2 Part I. Enter the disease, or complication is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Sudden Unexplained Death in Childhood Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

- Funeral Director: After this certificate has been signed by the attending physician and etel filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical X UNPENDED Items: 23a, 27, 28a-f per MEO G-883 9/16/08 reb Records, P.O. Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 V Yes 28a. Date of Injury (Month, Day, Year)Fnd 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending Yes 2 X No Unknown 7/18/2008 Fnd.8:01 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 Bryce Court 3 Suicide 6 X Could not be (Specify) House Nottingham, 4 Md. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the J within 2 To the J 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

29b. Signature and title of certifie

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 19, 2008

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple.

State of Maryland / Department of Health and Mental Hygien 2008

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY **Physician** ALBERT LANDER 2008 8:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 8810 WALTHER BLVD., APT. #220 PARKVILLE 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 6. Sex 1 ★ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months FRANCE Yrs. 03/12/1915 93 Director 086-01-2724 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hyglene.
ant: If Item 27 is marked other then "netural", or items 23a or 28e-f show ury or other treumatic event, I'm Medical Evanduet must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director MD BALTIMORE PARKVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8810 WALTHER BLVD., APT. #220 21234 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 X Married WHITE 1 □ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Completed by If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 **PLUMBER** PLUMBING & HEATING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be YISROEL **ROCHEL SCHUSTER** ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 WALTHER BLVD., APT. #220, PARKVILLE, MD 21234 SARAH LANDER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition JULY 23 20c. Location - City or Town, State permit. Peges 'Depertment of Himportant: if Ite eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State E. BRUNSWICK, NJ BETH ABRAHAM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ASLVD **Examiner** Due to (or as a consequence of): by Physician/Medical Examine The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): use ō Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? s certificate has b firector, page 2 s 1 Tyes 2 ₹No 1 ☐ Yes 2 ☐ No Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural s efter death.

I Director: Aff
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò e Hospital or 24 hours eff e Funerel Di 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the I within 2 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 058646 MO - mondo 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nov lova rd Perlevillo, MD 21234 Anna walthor Monias 8000 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 30 a M /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death **Examiner** MITTORD If Under 24 Hrs. Social Security Number 6. Sex Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 F Months Days Hours Min. Director Usual Residence of Decedent death with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Expodure mast be notified at 1 ☐Yes 2 ☐ No Director MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Pro Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than, Elementary/Secondary (0-12) i and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ဂ္ permit. Pages 1 and 2 sh.
Department of Health and
Important: If item 27 is ma Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death stade Physician Omunins disease or condition resulting in death) /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy perform this certificate 2 🗸 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) After the Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation thours after death. uneral Director: A sly filled in by the fu death. 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + 200 D Mannuel W 225

2008

Heather D. Mannuel

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Year)

31. Date filed (Month, Day,

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32. Registar's Signature

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21201

Baltimore MD

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician MAYBERRY 4c. County of Death 2008 AMES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Northwest Hospital 8. Date of Birth Month Day, Year) JAN 20 1918 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) Social Security Number Funeral 90 Ohio Director 193-05-3489 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notifled at 10b. County 10a. State 1 ☐ Yes 2 No Baltimore **Pikesville** Funeral Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 21208 must b USA 8909 Reisterstown Road, #4 raf", or Items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Accounting & Elementary/Secondary (0-12) College (1-4or 5+) Transportation Finance Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be filt tment of Health and Mental Hi tant: If item 27 is marked oth jury or other traumatic even Buffington Howard R. Mayberry Jennie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau 12 Rachel Court, Owings Mills, MD 21117 Barbara Gasper - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 7/21/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funest Service Licensee Williams ²² Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD_ 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BLEED GASTRO INTESTINAL /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or AttendIng PhysIcian: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Medical Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

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any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) West Arundel Crematory 07-14-08 Odenton, MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne Signature of Funeral 2719 Hammonds Ferry Rd. Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CONGESTIVE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** CURUNARY FEW YIS ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo 5 ☐ Other (specify) I∐Yes 2□No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be del δ STAGE RENAU DISEASE PERIPHERAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 6007 DISCASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nation 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

State Registrar

31. Date filed (Month, Day, Year)

MATGEN AWAR

29b. Signature and title of certifier



30. Name and audress of person who completed cause of death (Item 23a) (Type, Print)

2008

10802 HICKORY RIDGE ROAD

29c. License number

1)0:62634

COLUMBIA

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29d. Date signed (Month, Day, Year)

JULY 10 ,2008

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After this certificate funeral director, page the Hospital or Attending Physician: Division of Vital Director: , within 24 hours after d To the Funeral Direct completely filled in by Medical

1 V Natural Yes 2 No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. July 18, 2008

30. Name and address of person who completed cause of death (Item 23a)

2008

Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9881 7-22-08 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) John Marshall Physician 30 P W Della 9008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Baltmore Baltware 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 21, 1924 9. Birthplace (State or Foreig **Funeral** Min Months Days Hours Mary land M 2□ F Director 217-16-7073
Usual Residence of Decedent 84 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f shoved and examiner must be notified at 1√Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1701 Malvern Street 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Factory eath and Mental Hygic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Marshall Teresa Potoralska 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Maryann Marshall Fugate 4216 Shamrock Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Holy Rosary Cemetery 7/24/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical Examiner Donas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequate of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Ro 46 physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' certificate 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No npatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Co Medical 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D04383

Registrar

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2008

31. Date filed (Month, Day, Year)

30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 5505 H6741 15 Teay viaw Civele

			For State Registrar		(Certificate o	f Death		Reg. N	·2008	23500		
\$ N	Physici	an	1. Decedent's Name (First, Middle, La	10				2. Date of Month	D	ay Year	3. Time of Death 2:46 pm M		
	/Medic	al	4a. Façility Name (If not institution, giv	e street and number)		4b. City, Town	, or Location of De	ラス eath		Ic. County of Deat			
	Examin	er	University of n	longland Medi	al Cente	r Balti	more			N/A			
	Funeral Director		219-28-3939		(In yrs. last birth	day) If Under 1 Yearns. Months Day		lin. 8. Date of Month,	Birth Day, Yea	(r) Coi	nplace (State or Foreign untry) aryland		
land	t t		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits		
Mary	i-f sho	ρţ	MD Baltime	ore	Balt	imore					1 ☐ Yes 2 ☐ No		
th the	or 28s	Director	10e. Street and Number			10f. Zip Code				10g. Citizen of What Country?			
ath w	s 23a nust b	erall	7801 Penisula 1	Expressway 12. Was Decedent Ev				(Specify Vec or		S.A.	rican Indian		
rs after de	nt of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Tyyes 2 No If Yes, Give		13. Was Decedent of If Yes, specify Control of Image of		uerto Rican, etc.)	No	Black, White	e, etc.		
72 hou	natura Ilcal E		15. Decedent's Education (Specify only highest gra	ducation	16a. I	Decedent's Usual Occ Give kind of work dor		workina	16b.	Kind of Business/	Industry		
ithin 7	ne. han "ı e Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use reti	red)		C	arpentary	7		
filed	Hygie ther t		12 17. Father's Name (<i>First, Middle, Last</i>)		Carpenter	1	Name (First, Mide			<u> </u>		
d be	lental ked o ic eve	To Be	Charles Milton	Myers, Sr.			Edna	Wiebe					
2 shou	and M s mar sumat	-	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Stre	et and Number of	r Rural Route Nu	mber, City	y or Town, State, Z	ip Code)		
and 2	lealth m 27 I her tra		Dawn Zinner/ Daug	nter		05 Greence	ove Circ	le Sparr		Point, MI			
ges 1	Department of Health a Important: If Item 27 Is any Injury or other trainonce.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		cemetery	; crematory or other p		7/23/08		,	e, Maryland		
iit. Pa	artmer ortant: Injury		4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Lices		Lakev	iew Memori 22. Name and Add					ndalk, Inc.		
g em	Depar Impor any Ir		1ClOoper	((0)						aryland :			
	ę ~		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do no	ot enter the mode of o	lying, such as car	diac or respirator	y arrest,		Approximate Interval Between		
	ysician		Immediate Cause (Final disease or condition resulting in death)	a. Hemon	rhagic	stroke					Onset and Death		
	Medical aminer		resulting in death)	Due to (or as a	consequence of	·):							
s 2		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a	consequence o):							
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cate b	physician and s the burial-transit	Medical		ed									
The law requires that the death certificate be executed	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome portion 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal death	3 □Ectopic pregna 5 □ Other (specify)			-	23d. Date of del Month	ivery Day Year		
s that	ned by	by Ph	Part II. Other significant conditions	ontributing to death but	not resulting in	the underlying cause	given in Part I.	23e. D	id tobacco	o use contribute to	the cause of death?		
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The law r	ate has be	Completed						24a. W ai pe 1□ Ye	utopsy erformed	prior to death?	topsy findings available completion of cause of 2 ☐ No		
cian:	certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Other:	Death (Check on	-				
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ndlng	ith. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) In		Vork? □ Yes 2 □ No						
l or Atte	after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, fari (Specify)	n, street, factory, offic	ce		n (Street Town, Sta		ural Route Number,		
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	, v)		1/1/1/1/1/		dical nesi	cem	176435			July 12,	3008		
的	11		30. Name and address of person who		ath (Item 23a) (1	ype, Print)	ma mr	2120					
	Sta	te	Amy K. Oyler, Mr 31. Date filed (Month, Day, Year) JUL 2 2 200	2. Registrar	's Signature	bester Baltu	1145 1110	all)					
	Registr	ar	JUL 2 2 201	o person	N. 12								

DHMH 17 Rev 1/2001